

Case Number:	CM15-0042215		
Date Assigned:	03/12/2015	Date of Injury:	02/09/2015
Decision Date:	04/22/2015	UR Denial Date:	03/05/2015
Priority:	Standard	Application Received:	03/05/2015

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: New Jersey, Michigan, California

Certification(s)/Specialty: Neurology, Neuromuscular Medicine

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 25 year old male, who sustained an industrial injury on 2/9/2015. He reported a crush injury to the left fingers from a rock. The injured worker was diagnosed as having open fracture of the left distal phalanx. Treatment to date has included debridement and repair of the fracture and nail bed. Currently, a progress note from the treating provider dated 2/10/2015 indicates the injured worker reported tenderness at the surgical site.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Left hand orthosis: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, web edition, Forearm Wrist Hand section, Splints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Splints <http://www.odg-twc.com/index.html>.

Decision rationale: According to ODG guidelines, splints Recommended for treating displaced fractures. Immobilization is standard for fracture healing although patient satisfaction is higher

with splinting rather than casting. Treating fractures of the distal radius with casting versus splinting has no clinical difference in outcome. See also casting versus splints. Mallet finger: treatment commonly involves splinting of the finger for six or more weeks. Splints used for prolonged immobilization should be robust enough for everyday use, and of the central importance of patient adherence to instructions for splint use. (Handoll-Cochrane, 2004) For rheumatoid arthritis, there was generally a positive effect of splint use on hand function; however, perceived splint benefit was marginal. For most tasks splint use improved or did not change pain levels, did not interfere with work performance, increased or maintained endurance, and did not increase perceived task difficulty. The findings suggest that wrist splint prescription is not a simple process; clinicians and clients need to work together to determine the daily wear pattern that maximizes benefit and minimizes inconvenience according to the client's individual needs. (Pagnotta, 2005) See also Mallet finger (splinting) Following tendon repair: Recovery of finger function after primary extensor tendon repair depends on the complexity of trauma and the anatomical zone of tendon injury. Static splinting is an appropriate tool after primary extensor tendon repair in Verdan's zone 1, 2, 4 and 5, whereas injuries in zones 3 and 6 may demand for a different treatment regimen. (Carl, 2007) Arthritis: A recent randomized controlled study concluded that prefabricated wrist working splints are highly effective in reducing wrist pain after 4 weeks of splint wearing in patients with wrist arthritis. (Veehof, 2008) Hand splints can ease arthritis pain, according to a new systematic review. Short and rigid day splints cut hand pain in half after six months of use, according to one high-quality study. Another study found that hand pain was also cut in half by wearing a long rigid splint every night for a year, but the splints usually didn't improve hand function or strength. The findings mean that splints have about the same effect on pain as ibuprofen, the most common drug in osteoarthritis. A small splint for pain relief during the day combined with a custom-made and rigid splint for prevention of deformities at night may be an optimal regimen. (Kjeken, 2011) See also Casting; Casting versus splints. Although the patient developed open fracture of the left distal phalanx that required splinting, there is no documentation for the need of finger hand orthosis with dynamic flexor hinge. The patient condition is similar to Mallet finger and could be managed with a simple volar splint. Therefore, the request is not medically necessary.