

<b>Case Number:</b>	CM14-0140163		
<b>Date Assigned:</b>	09/08/2014	<b>Date of Injury:</b>	02/07/2012
<b>Decision Date:</b>	10/10/2014	<b>UR Denial Date:</b>	08/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/29/2014

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 47-year-old who reported an injury on February 7, 2012. The mechanism of injury was not provided. The injured worker was diagnosed with tendonitis of the right wrist. The past medical treatment included medications, physical therapy, epidural block injections, and bracing. Diagnostic testing included x-rays of the right wrist and hand. Surgical history was not provided. The injured worker complained of increased pain and intensity of the pain to the right wrist. The injured worker described the pain as a "throbbing electrical pain". The injured worker complained of weakness and frequent numbness in the right hand and tingling to right thumb, index, and little finger. The physical examination revealed diffuse palpable tenderness at the right wrist. The active range of motion radial deviation was 5 degrees on right and 20 degrees on left. Medications included Norco, Cymbalta. The treatment plan was for right and left wrist sleeve. The rationale for the treatment was not provided. The request for authorization was submitted on July 29, 14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right wrist sleeve and left wrist sleeve:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 263-264.

**Decision rationale:** The injured worker complained of increased pain and intensity of pain to right wrist. The California MTUS/ACOEM guidelines state splints are recommended as an initial treatment of carpal tunnel syndrome and should include night splints. Day splints can be considered for patient comfort as needed to reduce pain, along with work modifications. There is a lack of documentation of a diagnosis of carpal tunnel syndrome. There is a lack of documentation of physical examination of the left wrist as the request is for a bilateral wrist sleeve. There is a lack of documentation indicating the injured worker has significant objective functional improvement with the previous sleeve. The requesting physician's rationale for the request is not indicated within the provided documentation. Additionally, there is a lack of documentation indicating the injured worker's need for bilateral wrist sleeves as the injured worker utilized a wrist sleeve previously. Therefore the request for right wrist sleeve and left wrist sleeve is not medically necessary or appropriate.