

<b>Case Number:</b>	CM15-0111138		
<b>Date Assigned:</b>	06/17/2015	<b>Date of Injury:</b>	10/07/2014
<b>Decision Date:</b>	08/24/2015	<b>UR Denial Date:</b>	05/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/09/2015

### 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 York, West Virginia, Pennsylvania  
 Certification(s)/Specialty: Emergency 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 35 year old male, who sustained an industrial injury on October 7, 2014. He reported left wrist pain. The injured worker was diagnosed as having left wrist internal derangement and synovial cyst. Treatment to date has included diagnostic studies, radiographic imaging, conservative therapies, medications and work restrictions. Currently, the injured worker complains of continued left wrist pain. The injured worker reported an industrial injury in 2014, resulting in the above noted pain. He was treated conservatively without complete resolution of the pain. Evaluation on March 19, 2015, revealed continued left wrist pain. It was noted radiographic imaging of the left wrist did not reveal ligamentous tear but did reveal a small synovial cyst. Surgical intervention of the left wrist was recommended. Post-operative physical therapy, a cold therapy unit with compression, an inferential unit, a Pil-O splint nighttime wrist brace and a wrist support were requested.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Pil-O splint night wrist brace:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Forearm, wrist, & hand, splints.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, wrist and hand splints.

**Decision rationale:** Guidelines recommend splints for treating displaced fractures by immobilizing a fracture while healing. In this case, the requested procedure is not necessary. Therefore, the requested wrist splint, Pil-O splint night wrist brace, is not medically appropriate and necessary.

**IF unit times 14 day rental:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Interferential Current Stimulation (ICS).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain.

**Decision rationale:** Guidelines do not recommend IF as an isolated intervention but may be possibly appropriate in cases of pain refractory to medications. In this case, the requested procedure is not necessary. Therefore, the requested IF unit 14-day rental is not medically appropriate and necessary.

**Cold therapy unit with compression times 14 day rental:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, cold packs.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain.

**Decision rationale:** Guidelines recommend at home application of cold packs for the first few post op days. In this case, the requested procedure is not necessary. Therefore, the requested cold pack unit with compression 14-day rental, is not medically appropriate and necessary.

**Wrist support:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Forearm, wrist, & hand, splints.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) wrist splints.

**Decision rationale:** Guidelines recommend splints for treated displaced fractures and post surgical pain control. In this case, the requested procedure is not necessary. Therefore, the requested wrist splint is not medically appropriate and necessary.

