

<b>Case Number:</b>	CM15-0114718		
<b>Date Assigned:</b>	06/23/2015	<b>Date of Injury:</b>	08/09/2011
<b>Decision Date:</b>	08/18/2015	<b>UR Denial Date:</b>	06/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/15/2015

### 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: Illinois, California, Texas  
 Certification(s)/Specialty: Orthopedic Surgery

### CLINICAL CASE SUMMARY

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

This injured worker is a 59-year-old female with an industrial injury dated 8/09/11. Injury occurred when a client fell against her, knocking her to the ground, and then landed on top of her. Past medical history was positive for hypertension and depression. Social history was positive for smoking. Conservative treatment for the wrist had included medications, injections, physical therapy, and activity modification. The 5/27/15 treating physician report cited bilateral wrist pain and swelling greater on the left. Pain was aggravated by prolonged driving. Wrist pain was grade 2/10 on the right and grade 5/10 on the left. Physical exam documented tenderness over the 1st dorsal compartment, fairly symmetrical grip strength, and positive Finkelstein's greater on the left. Wrist range of motion was within normal limits. The diagnosis was DeQuervain's stenosing tenosynovitis of the both wrists, mild on the right. Authorization was requested for left DeQuervain's release, post-op physical therapy x 8, post-operative wrist brace, cold therapy unit for 3 weeks, purchase of a home therapy kit for rehabilitation, and pre-operative labs, EKG, and chest x-ray. The 6/8/15 utilization review certified the request for left DeQuervain's release and post-op physical therapy. The request for cold therapy unit for 3 weeks was non-certified as there was no guideline support for a cold therapy unit over standard cold packs for post-operative edema control. The request for wrist brace was non-certified as not medically indicated for support after a wrist tendinitis release. The request for purchase of a home therapy kit was non-certified as there was no medical rationale to support this after surgery and the allotted therapy and beyond a home exercise program. The request for pre-operative

chest x-ray was not medically necessary as there were no significant medical conditions and pre-operative labs and EKG had been certified.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Cold Therapy Unit for three weeks: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 264. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist & Hand: Cold Packs: Carpal tunnel syndrome: Continuous cold therapy (CCT).

**Decision rationale:** The California MTUS is silent regarding cold therapy units, but support the use of standard cold packs for patients with wrist/hand complaints. The Official Disability Guidelines recommend cold packs for wrist and hand complaints, and state that continuous cold therapy is an option for up to 7 days in the post-operative setting following carpal tunnel release. There is no compelling rationale presented to support the medical necessity of a cold therapy unit over standard cold packs following the certified DeQuervain's release surgery. Additionally, guidelines limit the use of a cold therapy unit to 7 days when supported. Therefore, this request is not medically necessary.

#### **Wrist Brace: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 264. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist & Hand: Splints.

**Decision rationale:** The California MTUS and Official Disability Guidelines support the use of wrist bracing for symptom control. This request for a post-operative wrist brace is consistent with guidelines for pain control and early return to functional activities. Therefore, this request is medically necessary.

#### **Home Therapy Kit for Purchase: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Exercise Page(s): 46-47.

**Decision rationale:** The California MTUS supports the use of exercise for patients in the post-operative period. Exercise programs are reported superior to treatment programs that do not include exercise. Guidelines state that there is no sufficient evidence to support the recommendation of any particular exercise regime over any other exercise regime. Guideline criteria have not been met. There is no compelling reason to support the medical necessity of this pre-packaged generic exercise kit over an individualized home exercise program designed by the patient's physical therapist. Therefore, request is not medically necessary.

**Chest X-ray:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACR Appropriateness Criteria® routine admission and preoperative chest radiography. Reston (VA): American College of Radiology (ACR); 2011. 6 p.

**Decision rationale:** The California MTUS guidelines do not provide recommendations for this service. Evidence based medical guidelines state that routine pre-operative chest radiographs are not recommended except when acute cardiopulmonary disease is suspected on the basis of history and physical examination. Middle-aged females who smoke have known occult increased cardiopulmonary risk factors to support the medical necessity of pre-procedure chest x-ray. Guideline criteria have been met based on patient age, smoking status, hypertension, and the risks of undergoing anesthesia. Therefore, this request is medically necessary.