

<b>Case Number:</b>	CM15-0115424		
<b>Date Assigned:</b>	06/23/2015	<b>Date of Injury:</b>	07/31/2012
<b>Decision Date:</b>	07/28/2015	<b>UR Denial Date:</b>	05/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/16/2015

### 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: California, Massachusetts

Certification(s)/Specialty: Preventive Medicine, Occupational 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 65 year old female who sustained an industrial injury on 07/31/2012. Mechanism of injury occurred when she developed gradual onset of right upper extremity and cervical pain due to tasks such as use of a computer and mouse. Diagnoses include radial styloid tenosynovitis, osteoarthritis involving the hand, trigger finger, pain in joint involving the hand, acquired spondylolisthesis, cervicalgia, degenerating of the cervical intervertebral disc, insomnia, and rotator cuff syndrome. Treatment to date has included diagnostic studies, medications, surgery, splints, acupuncture, physical therapy, right thumb carpometacarpal joint corticosteroid injection and carpometacarpal arthroplasty on 12/10/2014, and occupational therapy. An unofficial Electromyography/and Nerve Conduction Velocity done in April of 2015 showed mild right cubital tunnel, no carpal tunnel syndrome. X rays done at the office on 04/27/2015 showed right hand degenerative joint space narrowing at the 1st carpometacarpal (CMC) and at the scaphotrapezotrapezoidal (STT joint). A physician progress note dated 04/27/2015 documents the injured worker is doing well but having some issues. She is having a lot of worsening numbness/tingling, weakness, swelling, and sensitivity. She is having a lot of pain in her right thumb, mostly volar side but also dorsal and base. She still experiences significant swelling and weakness. She still cannot open jars, and there is a lot of sensitivity along the incision. Her numbness is worsening. She is now wakes up at night with tingling and the numbness is now constant. Wrist range of motion is mildly restricted, and thumb and finger range of motion is restricted. Light stroke sensory testing is decreased in the right thumb, index

and middle digit. Treatment requested is for bilateral trigger finger splints, and right prefab wrist splint.

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

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

**Bilateral trigger finger splints:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265.

**Decision rationale:** While MTUS guidelines are silent, ACOEM guidelines discuss standard of care in treating trigger finger. According to ACOEM guidelines, conservative measures such as OT, stretching, ice, and medications such as NSAID are first line treatment followed by a series of 2 steroid injections. There is no mention of splinting being routine treatment for trigger fingers. This is likely due to the high success of other conservative measures listed above and the low proven efficacy of splinting. Considering the above and lack of proven efficacy in the clinical guidelines, the requested trigger finger splints are not medically necessary.

**Right prefab wrist splint:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265.

**Decision rationale:** According to the most recent clinic note provided on 4/27/15, the patient is "tolerating splint OK, she is in therapy and motions continue to improve". The IW apparently has been effectively treated by a generic adjustable wrist splint with good efficacy. The cited guidelines do not address the necessity or proven benefit of prefab wrist splints over generic adjustable wrist splints. Considering the lack of guidelines and the reported efficacy with the patient's current wrist splint, the request for a new prefab splint is not medically necessary.