

<b>Case Number:</b>	CM13-0015718		
<b>Date Assigned:</b>	03/19/2014	<b>Date of Injury:</b>	07/17/1995
<b>Decision Date:</b>	04/15/2014	<b>UR Denial Date:</b>	08/13/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/23/2013

### 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 Internal Medicine and Pulmonary Diseases 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 patient is a 58-year-old male who reported an injury on 07/17/1995, due to cumulative trauma while performing normal job duties. The submitted request is for a diagnostic ultrasound with guided injection for date of service 11/14/2011. There was no documentation from the date of service supporting the request.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **RETRO REQUEST FOR 1 DIAGNOSTIC ULTRASOUND WITH GUIDED INJECTION (DOS: 11/14/11): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, CARPAL TUNNEL SYNDROME (ACUTE & CHRONIC).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines FUNCTIONAL RESTORATION APPROACH TO CHRONIC PAIN Page(s): 9.

**Decision rationale:** The Chronic Pain Guidelines indicate "when choosing an invasive procedure to treat a specific chronic pain problem, a complex judgment is necessary to make sure that the desired and expected outcome is worth the risk involved, depending on the procedure and individual risk factors." As there was no assessment from the requested date of service, the

appropriateness of this procedure cannot be determined. Additionally, no documentation of failure to respond to conservative treatments prior to the requested procedure was provided. The need for an invasive procedure cannot be determined. As such, the retrospective request for one (1) diagnostic ultrasound with guided injection for date of service 11/14/2011 is not medically necessary or appropriate.