

Case Number:	CM13-0025091		
Date Assigned:	11/20/2013	Date of Injury:	09/12/2008
Decision Date:	01/14/2014	UR Denial Date:	08/23/2013
Priority:	Standard	Application Received:	09/17/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & 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 physician 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 35-year-old male who reported an injury on 09/12/2008, due to an altercation with an inmate. The patient was treated conservatively with physical therapy and medication. The patient underwent a right wrist MRI that revealed a ganglion cyst. The patient underwent ganglion cyst excision and arthroscopy of the wrist. The patient underwent an additional MRI that did not provide evidence of any issues with the wrist. The patient had persistent wrist pain complaints. The patient had persistent knee complaints. The most recent clinical evaluation of the right wrist revealed range of motion described as 60 degrees of extension and 45 degrees of flexion with pain with ulnar deviation and direct palpation and a positive impaction test over the TFCC. It is also noted that the patient had a positive Finkelstein's test. Evaluation of the right knee revealed range of motion described as 0 to 120 degrees with a positive Apley's compression distraction test. The patient's diagnoses included left wrist pain, right wrist de Quervain's tenosynovitis, right knee arthritis, and left knee pain. The patient's treatment plan included 3 Euflexxa injections with right knee ultrasound and an MR arthrogram of the right wrist.

IMR ISSUES, DECISIONS AND RATIONALES

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

Request for right wrist MRI with intra articular contrast (arthrogram): 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): 272.

Decision rationale: The right wrist MRI with intra articular contrast (arthrogram) is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the patient has persistent pain complaints related to the right wrist. The American College of Occupational and Environmental Medicine state that arthrography is supported when the patient is considered a surgical candidate. The clinical documentation submitted for review does not provide any evidence that the patient is a surgical candidate. Additionally, Official Disability Guidelines only recommend repeat imaging when there is a significant change in pathology. The clinical documentation submitted for review does indicate that the patient had a postsurgical MRI that did not provide any evidence of internal derangement. Therefore, as there has not been a significant change in the patient's clinical presentation, repeat imaging would not be indicated. As such, the requested right wrist MRI with intra-articular contrast (arthrogram) is not medically necessary or appropriate.

Request for ultrasound guidance: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Knee (updated 6/7/13)..

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Physician Reviewer based his/her decision on Official Disability Guidelines (ODG) Knee and Leg Chapter, Ultrasound guid

Decision rationale: The request for ultrasound guidance is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the patient is scheduled to undergo knee injections. Official Disability Guidelines recommend ultrasound guidance for knee injections when there is an initial failure to perform a knee injection without ultrasound guidance; the patient's size interferes with the ability to inject the knee, or the draining of a popliteal cyst. The clinical documentation submitted for review does not indicate that the patient has had a failed attempt with a previous knee joint injection or that the patient's size would interfere with the ability to be provided a knee injection without ultrasound guidance. As such, the requested ultrasound guidance is not medically necessary or appropriate.