

<b>Case Number:</b>	CM13-0028297		
<b>Date Assigned:</b>	06/06/2014	<b>Date of Injury:</b>	06/04/2013
<b>Decision Date:</b>	07/18/2014	<b>UR Denial Date:</b>	09/13/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/23/2013

### 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 Physical Medicine and 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 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 injured worker is a 50 year old male who reported an injury on 06/04/2013. The mechanism of injury as described by the injured worker was lifting a bag and loaded it on a bag cart. The injured worker complained of pain to the right wrist and left forearm. The physical exam noted tenderness to deep palpation over the distal left biceps tendon area, negative Tinel's sign over the left cubital tunnel & medial elbow, negative Tinel's sign over the median and ulnar nerves at the right wrist, negative Phalen's sign bilaterally, negative Finkelstein's bilaterally and no finger triggering noted bilaterally. An X-ray was completed on 06/12/2013. The injured worker's diagnosis includes wrist, carpal sprain/strain, forearm sprain/strain and elbow & upper arm pain. Previous treatments included 12 completed sessions of physical therapy and medications. The medications noted was ibuprofen 600mg. The requested treatment plan was for additional physical therapy, continue with current medications and a magnetic resonance imaging (MRI) of the right wrist and left elbow.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **MAGNETIC RESONANCE IMAGING (MRI) LEFT ELBOW: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 42-43.

**Decision rationale:** The request magnetic resonance imaging (MRI) left elbow is non-certified. The injured worker has a history of pain to the left arm and right wrists and has completed 12 sessions of physical therapy with noted improvement and continues with ibuprofen for medication. The American College of Occupational and Environmental Medicine (ACOEM), states special studies are not needed unless a period of at least 4-weeks of conservative care and observation fails to improve their symptoms. The documentation noted the injured worker has completed physical therapy but it does not indicate to which area therapy was focused on. Also there is a lack of quantifiable documentation in the areas of range of motion and strength. The documentation noted that the injured worker used ibuprofen but it did not provide the frequency nor the injured worker's pain rating with and without the medication. There was also a lack of documentation to show other medication was used and failed to improve the injured worker's symptoms. Documentation submitted does not show at least 4-weeks of conservative care and observation failure to improve symptoms. Based on the above noted, the request is non-certified.

**MAGNETIC RESONANCE IMAGING (MRI) RIGHT WRIST:** 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): 268-269.

**Decision rationale:** The request magnetic resonance imaging (MRI) right wrist is non-certified. The injured worker has a history of pain to the left arm and right wrists and has completed 12 sessions of physical therapy with noted improvement and continues with ibuprofen for medication. The American College of Occupational and Environmental Medicine (ACOEM), states special studies are not needed until after a 4- to 6-week period of conservative care and observation. The documentation noted the injured worker has completed physical therapy but it does not indicate to which area therapy was focused on. Also there is a lack of quantifiable documentation in the areas of range of motion and strength. The documentation noted that the injured worker used ibuprofen but it did not provide the frequency nor the injured worker's pain rating with and without the medication. There was also a lack of documentation to show other medication was used and failed to improve the injured worker's symptoms. Documentation submitted does not show 4- to 6-weeks of conservative care and observation failure to improve symptoms. Based on the above noted, the request is non-certified.

**ADDITIONAL PHYSICAL THERAPY 2X3 LEFT ELBOW:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE Page(s): 98-99.

**Decision rationale:** The request for physical therapy 2x3 left elbow is non-certified. The injured worker has a history of pain to the left arm and right wrists and has completed 12 sessions of physical therapy and continues with ibuprofen for medication. The California MTUS recommends physical medicine to allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home physical medicine. The documentation provided noted completion of physical therapy with improvement but does not indicate a fading of treatment frequency was followed. The additional request for physical therapy does not follow a fading of treatment frequency. Based on the above noted, the request is non-certified.

**ADDITIONAL PHYSICAL THERAPY 2X3 RIGHT WRIST:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE Page(s): 98-99.

**Decision rationale:** The request for physical therapy 2x3 right wrist is non-certified. The injured worker has a history of pain to the left arm and right wrists and has completed 12 sessions of physical therapy and continues with ibuprofen for medication. The California MTUS recommends physical medicine to allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home physical medicine. The documentation provided noted completion of physical therapy with improvement but does not indicate a fading of treatment frequency was followed. The additional request for physical therapy does not follow a fading of treatment frequency. Based on the above noted, the request is non-certified.