

Case Number:	CM14-0105512		
Date Assigned:	07/30/2014	Date of Injury:	05/19/2012
Decision Date:	10/14/2014	UR Denial Date:	07/01/2014
Priority:	Standard	Application Received:	07/08/2014

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 Nevada. 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 records, presented for review, indicate that this 59-year-old female was reportedly injured on May 19, 2012. The mechanism of injury was not disclosed. A recent progress note, dated June 18, 2014, demonstrated ongoing pain in the wrist. This progress report indicated there were no symptoms of numbness or tingling; however, this is in contradiction to almost every other progress note provided dating back to January 2014 and as recent as May 2014. A notation was made that the claimant did not receive benefit from either intra-articular or carpal canal injections. The physical examination demonstrated a negative Tinel's test, positive carpal tunnel compression test only for pain in the wrist but with no numbness or tingling, a positive owner grind test, pain at the fovea, and a stable DRUJ. The progress note then went on to state that the claimant did receive some benefit from the carpal tunnel injection. The provider indicates he feels that the MRI was of moderate quality and that because of the claimant's ongoing symptoms, a repeat MR arthrogram in a higher quality facility was recommended. The record noted that the claimant also has CMC arthritis that is being followed. The medical record also referenced multiple other complaints, followed by other providers, including shoulder symptoms, cervical spine symptoms, and history of a stroke affecting the right upper extremity. Diagnostic imaging studies have included an EMG, which was normal. An MRI of the wrist was normal along with a MRI of the shoulder and an MRI of the cervical spine. Previous treatment included physical therapy, pharmacotherapy, activity modifications, surgical intervention for the right shoulder, bracing for the wrist, NSAIDs for the wrist, injections for the wrist. The medical record also referenced an MRI of the lumbar spine and the possibility of epidural steroid injections, but the documentation did not indicate that these were or were not provided. A request had been made for an MRI arthrogram of the right wrist and was not certified in the pre-authorization process on July 1, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI Arthrogram - Right Wrist: 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): Electronically Cited.

Decision rationale: ACOEM guidelines support the use of MR arthrography for the diagnosis of TFCC tears. The medical record indicates that the claimant has undergone MRI imaging and it is the provider's opinion that this film is of suboptimal quality. In general, the guidelines do not support repeat advanced imaging in the absence of a change in clinical symptoms. There has been no reference or indication that this film has been reviewed by anyone else with the same opinion. Review of the clinical presentation indicates that the claimant has failed to respond to injection, and continues to present in a manner that the treating physician feels internal derangement is present. The typical standard of care for internal derangement not identified on advanced imaging would be consideration for arthroscopy. There is no discussion in the medical record as to why repeating a study that has already been performed. A negative is preferred over arthroscopy; and the clinical data, provided, does not substantiate the medical necessity of repeating this study in the absence of a change in symptomatology. Based on the clinical information available, this request is not medically necessary.