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| Case Number: | CM14-0127642 | | |
| Date Assigned: | 09/23/2014 | Date of Injury: | 07/14/2000 |
| Decision Date: | 11/17/2014 | UR Denial Date: | 07/28/2014 |
| Priority: | Standard | Application Received: | 08/12/2014 |

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 Internal Medicine; has a subspecialty in 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 injured worker is a 63-year-old male who reported an injury on 07/14/2000. The mechanism of injury was not submitted for review. The injured worker has a diagnosis of degeneration of cervical intervertebral disc. Physical medical treatment consists of surgery, injections, physical therapy, and medication therapy. Medications include baclofen, gabapentin, Pennsaid drops, Vicodin tablet 5/500 mg, Vicoprofen, and Zanaflex. The injured worker has undergone x-rays and MRIs. On 06/17/2014, the injured worker complained of hand pain and cervical spine pain. Physical examination revealed that the cervical spine was positive for paraspinal spasm. Trigger points were positive at the trapezius, rhomboids, and supraspinatus. Deep tendon reflexes were normal bilaterally. Range of motion was decreased to 50% due to pain. Sensory exam was abnormal and motor exam was normal. The treatment plan is for the injured worker to undergo an x-ray of the right wrist. The rationale and request for authorization form were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right wrist x-ray: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-8.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-269.

Decision rationale: The request for right wrist x-ray is not medically necessary. ACOEM/MTUS Guidelines state for most patients presenting with true hand and wrist problems, special studies are not needed until after a 4 to 6 week period of conservative care and observation. Most patients improve quickly, provided red flag conditions are ruled out. Expectations include the following: in cases of wrist injury with snuffbox tenderness but minimal other findings, a scaphoid fracture may be present; initial radiographic films may be obtained but may be negative in the presence of scaphoid fracture. Radiographic films may show a fracture: stress views if obtainable, may show laxity. The diagnoses may necessitate surgical repair of the ligament: therefore, a surgical referral is warranted. The submitted documentation did not indicate any red flag condition. Furthermore, there was no rationale as to how the results of the x-ray would be used to direct future care of the injured worker. Given that there was no indication of the injured worker having to undergo surgery of the wrist, the injured worker is not within guideline criteria. As such, the request is not medically necessary.