

Case Number:	CM14-0053892		
Date Assigned:	07/07/2014	Date of Injury:	05/27/2012
Decision Date:	09/05/2014	UR Denial Date:	03/31/2014
Priority:	Standard	Application Received:	04/21/2014

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 & Rehabilitation has a subspecialty in Pain Medicine 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 55-year-old female with an original date of injury of may 27 2012. The injured worker sustained the injury when she was struck on the left hand and thumb by a swinging door. The patient developed subsequent bilateral shoulder, right elbow, left hand and thumb pain. The patient also had associated depressive symptoms and sleep disturbance. Conservative treatments to date have included Celebrex, Cyclobenzaprine, home therapy, some Spica splint, moist heating pad, physical therapy, and wrist brace. The patient has had MRI of the left wrist on September 5, 2012 which revealed degenerative changes of the 1st carpometacarpal joint and pisotriquetral joints. A utilization review determination on date of service March 31, 2014 had modified the request for acupuncture from 12 visits to 6 visits. The request for MRI of the left wrist and 12 visits of physical therapy was non certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the left wrist: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Forearm, Wrist and Hand Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 9 Shoulder Complaints Page(s): 268-269. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hand, Wrist, Forearm Chapter, MRI.

Decision rationale: Section 9792.23.4 Forearm, Wrist, and Hand Complaints of the California Code of Regulations, Title 8, page 5 states the following: "The Administrative Director adopts and incorporates by reference the Forearm, Wrist, and Hand Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11) into the MTUS from the ACOEM Practice Guidelines." ACOEM Chapter 11 on pages 268-269 state the following regarding wrist/hand imaging studies: "For most patients presenting with true hand and wrist problems, special studies are not needed until after a four- to six-week period of conservative care and observation. Most patients improve quickly, provided red flag conditions are ruled out. Exceptions include the following: - In cases of wrist injury, with snuff box (radial-dorsal wrist) 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. A bone scan may diagnose a suspected scaphoid fracture with a very high degree of sensitivity, even if obtained within 48 to 72 hours following the injury. - An acute injury to the metacarpophalangeal joint of the thumb, accompanied by tenderness on the ulnar side of the joint and laxity when that side of the joint is stressed (compared to the other side), may indicate a gamekeeper thumb or rupture of the ligament at that location. Radiographic films may show a fracture; stress views, if obtainable, may show laxity. The diagnosis may necessitate surgical repair of the ligament; therefore, a surgical referral is warranted. - In cases of peripheral nerve impingement, if no improvement or worsening has occurred within four to six weeks, electrical studies may be indicated. The primary treating physician may refer for a local lidocaine injection with or without corticosteroids. - Recurrence of a symptomatic ganglion that has been previously aspirated or a trigger finger that has been previously treated with local injections (see Table 11-4) is usually an indication for re-aspiration or referral, based on the treating physician's judgment. - A number of patients with hand and wrist complaints will have associated disease such as diabetes, hypothyroidism, Vitamin B complex deficiency and arthritis. When history indicates, testing for these or other comorbid conditions is recommended. - If symptoms have not resolved in four to six weeks and the patient has joint effusion, serologic studies for Lyme disease and autoimmune diseases may be indicated. Imaging studies to clarify the diagnosis may be warranted if the medical history and physical examination suggest specific disorders. Table 11-6 provides a general comparison of the abilities of different imaging techniques to identify physiologic insult and define anatomic defects." Table 11-6 on page 269 indicates that hand/wrist MRI is recommended for the diagnosis of carpal tunnel syndrome and infection, but not for ligament/tendon strain, tendinitis/tenosynovitis, DeQuervain's tendonitis, trigger finger, and ganglion. Further guidelines are described by the Official Disability Guidelines, which state the following regarding hand/wrist MRI: "Recommended as indicated below. While criteria for which patients may benefit from the addition of MRI have not been established, in selected cases where there is a high clinical suspicion of a fracture despite normal radiographs, MRI may prove useful. (ACR, 2001) (Schmitt, 2003) (Valeri, 1999) (Duer, 2007) Magnetic resonance imaging has been advocated for patients with chronic wrist pain because it enables clinicians to perform a global examination of the osseous and soft tissue structures. It may be diagnostic in patients with triangular fibrocartilage (TFC) and intraosseous ligament tears, occult fractures, avascular neurosis, and miscellaneous other abnormalities. Many articles dispute the value of imaging in

the diagnosis of ligamentous tears, because arthroscopy may be more accurate and treatment can be performed along with the diagnosis. (Dalinka, 2000) (Tehranzadeh, 2006) For inflammatory arthritis, high resolution in-office MRI with an average followup of 8 months detects changes in bony disease better than radiography, which is insensitive for detecting changes in bone erosions for this patient population in this time frame. (Chen, 2006) See also Radiography. Indications for imaging -- Magnetic resonance imaging (MRI):- Acute hand or wrist trauma, suspect acute distal radius fracture, radiographs normal, next procedure if immediate confirmation or exclusion of fracture is required- Acute hand or wrist trauma, suspect acute scaphoid fracture, radiographs normal, next procedure if immediate confirmation or exclusion of fracture is required- Acute hand or wrist trauma, suspect gamekeeper injury (thumb MCP ulnar collateral ligament injury)- Chronic wrist pain, plain films normal, suspect soft tissue tumor- Chronic wrist pain, plain film normal or equivocal, suspect Kienbock's disease- Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. (Mays, 2008)"In the case of this injured worker, there is no clear documentation of the need for left wrist MRI. I do not see in the progress notes a recent left wrist examination. There are notes of left wrist MRI with contrast on July 1, 2014. However, preceding this note there does not appear to be a progress note associated with the request for MRI. This request is not medically necessary.

Twelve visits of physical therapy for the flaring bilateral upper extremity pain: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99.

Decision rationale: At this juncture, this is a chronic injury and the patient likely has undergone previous physical therapy to address this issue. The submitted documentation does not contain a comprehensive assessment of what response the patient had 2 prior therapy. It is not appropriate to undergo a full formal course of physical therapy, and this request is not medically necessary

Acupuncture for flaring bilateral upper extremity pain: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The guidelines clearly specify that the number of visits to demonstrate functional improvement is 4 to 6 visits of acupuncture. Therefore the original request of 12 visits was outside of guidelines, and the utilization review determination of modifying to 6 visits is appropriate.