

<b>Case Number:</b>	CM14-0066013		
<b>Date Assigned:</b>	07/11/2014	<b>Date of Injury:</b>	02/11/2014
<b>Decision Date:</b>	09/03/2014	<b>UR Denial Date:</b>	04/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/09/2014

### 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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 sustained an injury to his right upper extremity on 02/11/14 while cleaning a machine; he cut his left hand on the disc of the machine. The injured worker sustained multiple bleeding lacerations with RRF extensor tendon visibly lacerated. Physical examination of the left hand noted LIF 6mm total length of lacerations to radial proximal phalanx/proximal interphalangeal (PIP) joint without joint or tendon involvement; left hand (dorsum) macerated 9mm total laceration to dorsal left hand and MCP joints, LMF/LRF/fourth webspace with extensor tendon involvement at level of Metacarpophalangeal (MCP); 30% lass tendon macerated without lag; palpation 2+ tenderness; range of motion normal; motor strength not examined; Jamar circulatory normal plus pulses in color the injured worker reported pain 6-10/10 visual analog pain scale radiating into fingers of the left arm with associated numbness and tingling. Clinical note dated 03/18/14 reported that the injured worker pain increased with movement and at night, decreased with medication. The injured worker had difficulty with following activities of daily living. Additional examination of the left wrist and hand revealed no instability, laxity, ecchymosis, abrasions, or surgical scars.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**12 Acupuncture sessions for date of service 3/18/14 and 6/14/14: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability guidelines.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** The request for 12 acupuncture sessions for date of service 3/18/14 and 6/14/14 is not medically necessary. Previous request was denied on the basis that according to the records, the injured worker continued to suffer from left wrist, hand, and right shoulder pain. Acupuncture is not recommended as highly for the shoulder as for other body parts. In addition, guidelines state that acupuncture is not recommended for the wrist/hand. After reviewing the clinical documentation submitted for review, there was no additional significant objective clinical information provided that would support reversing the previous adverse determination. Given this, the request for 12 acupuncture sessions for date of service 3/18/14 and 6/14/14 is not indicated as medically necessary.

**4 Functional restoration sessions for the left hand for date of service 3/18/14 and 6/14/14:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 258, Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs (functional restoration programs) Page(s): 30-32.

**Decision rationale:** The request for 4 functional restoration sessions for the left hand for date of service 3/18/14 and 6/14/14 is not medically necessary. Previous request was denied on the basis that upon review of the records, the injured worker has not met all the criteria that would warrant functional restoration program at this time specifically, the injured worker has not yet begun therapeutic treatment that may result in functional improvement, such as chiropractic or acupuncture. Furthermore, there is no indication that the injured worker underwent a psychological evaluation prior to the request. Given this, the request for 4 functional restoration sessions for the left hand for date of service 3/18/14 and 6/14/14 is not indicated as medically necessary.

**1 MRI of the right shoulder for date of service 3/18/14 and 6/14/14:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 68, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official disability guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Magnetic resonance imaging (MRI).

**Decision rationale:** The request for MRI of the right shoulder for date of service 3/18/14 and 6/14/14 is not medically necessary. The previous request was denied on the basis that it did not appear the injured worker continued to have symptoms and limitations in spite of conservative care for more than one month. Therefore, a trial of conservative care is appropriate prior to the

possibility of MRI. After reviewing the clinical documentation, there was no additional significant objective clinical information provided for review that would support reversing the previous adverse determination. Given this, the request for MRI of the right shoulder for date of service 3/18/14 and 6/14/14 is not indicated as medically necessary.

**1 Left hand surgeon consultation for date of service 3/18/14 and 6/14/14: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) <Forearm, wrist and hand chapter, Office visits.

**Decision rationale:** The request for 1 left hand surgeon consultation for date of service 3/18/14 and 6/14/14 is not medically necessary. The previous request was denied on the basis that upon review of the records, initial x-rays of the wrist/hand were negative for fracture. There was no gross deformity of the hand. It is possible surgical consultation may be appropriate in the future opinion additional information from authorized diagnostic testing; at this time it seems premature. After reviewing the clinical documentation submitted for review, there was no additional significant objective clinical information that would support reversing the previous adverse determination. Given this, the request for 1 left hand surgeon consultation for date of service 3/18/14 and 6/14/14 is not indicated as medically necessary.

**1 Range of motion and muscle testing for date of service 3/18/14 and 6/14/14: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, wrist and hand chapter, Computerized muscle testing.

**Decision rationale:** The request for 1 range of motion and muscle testing for date of service 3/18/14 and 6/14/14 is not medically necessary. Previous request was denied on the basis that guidelines state that computerized muscle testing for the extremities is not recommended due to the ability to compare muscle strength to the other side. The same is true for range of motion testing for the extremities. The Official Disability Guidelines state that deficit definition is quite adequate with usual exercise equipment given the physiological reality of slight performance variation dated day to day due to multitude of factors that always vary human performance. This would be an unneeded test. Given this, the request for 1 range of motion and muscle testing for date of service 3/18/14 and 6/14/14 is not indicated as medically necessary.