

Case Number:	CM14-0082433		
Date Assigned:	07/21/2014	Date of Injury:	06/18/2012
Decision Date:	10/01/2014	UR Denial Date:	05/06/2014
Priority:	Standard	Application Received:	06/03/2014

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 Orthopedic Surgery, 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 52-year-old female who reported an injury on 06/18/2012 caused by an unspecified mechanism. The injured worker's treatment history included MRI studies, x-rays, and physical therapy. The injured worker was evaluated on 04/22/2014 and it was documented that the injured worker complained of left wrist pain was status post triangular fibrocartilage complex (TFCC) repair. The injured worker noted more swelling since the sutures were removed on 04/14/2014. There was quite a bit of swelling in the fingertips, some numbness, tingling, and exquisite pain with any movements. There appeared to be no signs of infection where the sutures were removed. The injured worker was very sensitive to any movement. The injured worker had to use the left hand to pick up the right hand to move it. There was much swelling in all the fingers and hand, as well as to the mid of the forearm. There was also swelling noted in the 4th digit, so much that there was a blister with some drainage. The blister was applied with Neosporin and wrapped in a Band-Aid. It appeared to be well healed. There was possible reflex sympathetic dystrophy (RSD). Objective findings: there was exquisite tenderness to the wrist and forearm with edema noted throughout the fingers and hand, approximately 2 inches into the forearm along the right. There was a small blister on the inside of the 4th digit, which was healing with no signs of erythema, swelling, or infection. There was no drainage on the date of the visit. Sensation was intact throughout the fingers and hand. The provider could manually bend each of the fingers, as well as the wrist, although it caused increased discomfort. The injured worker had element of depression. Diagnoses included wrist joint inflammation with TFCC ligament tear, extensor carpi ulnaris tenosynovitis, ganglion cyst along scapholunate area, and TFCC ligament radial tear with median nerve inflammation. The Request for Authorization dated 04/22/2014 was for a nuclear bone scan.

IMR ISSUES, DECISIONS AND RATIONALES

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

Nuclear bone scan: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Complex regional pain syndrome (CRPS) Page(s): 36-37.

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

Decision rationale: The request for nuclear bone scan is not medically necessary. MTUS/ACEOM guidelines state that 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. 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 metatarsophalangeal 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. Imaging studies to clarify the diagnosis may be warranted if the medical history and physical examination suggest specific disorders. Per the guidelines the bone scan should be obtained within 72 to 48 hours following injury. As such, the request for nuclear bone scan is not medically necessary.