

Case Number:	CM14-0190655		
Date Assigned:	11/24/2014	Date of Injury:	06/24/2013
Decision Date:	01/09/2015	UR Denial Date:	10/30/2014
Priority:	Standard	Application Received:	11/14/2014

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 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:

This 48 year-old patient sustained a repetitive cumulative injury on 6/24/13 while employed. Request(s) under consideration include MRI without contrast, right forearm. Diagnoses include right forearm pain; wrist sprain; right CTS; right medial epicondylitis; myofascial pain syndrome; low back pain; rotator cuff injury; long-term medication use; and mixed anxiety and depressed mood. Conservative care has included medications, therapy, wrist bracing, injections, and modified activities/rest. EMG/NCV revealed no evidence of cervical radiculopathy or entrapment neuropathy in the upper extremities. Report of 9/30/14 from the provider noted the patient with chronic ongoing low back, right shoulder, right elbow and right hand pain. Symptoms remained unchanged and the patient was unsure whether the steroid injection provided any relief. Brief exam noted normal gait; mild distress, anxious and depressed. No other exam was documented. The patient remained TTD. The request(s) for MRI without contrast, right forearm was non-certified on 10/30/14 citing guidelines criteria and lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI without contrast, right forearm: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-269. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm/Wrist & Hand (Diagnostic), page 182

Decision rationale: Request(s) under consideration include MRI without contrast, right forearm. Diagnoses include right forearm pain; wrist sprain; right CTS; right medial epicondylitis; myofascial pain syndrome; low back pain; rotator cuff injury; long-term medication use; and mixed anxiety and depressed mood. Conservative care has included medications, therapy, wrist bracing, injections, and modified activities/rest. EMG/NCV revealed no evidence of cervical radiculopathy or entrapment neuropathy in the upper extremities. Report of 9/30/14 from the provider noted the patient with chronic ongoing low back, right shoulder, right elbow and right hand pain. Symptoms remained unchanged and the patient was unsure whether the steroid injection provided any relief. Brief exam noted normal gait; mild distress, anxious and depressed. No other exam was documented. The patient remained TTD. Criteria for ordering imaging studies such include Emergence of a red flag; Physiologic evidence of tissue insult or neurologic dysfunction; Failure to progress in a strengthening program intended to avoid surgery; Clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination and electrodiagnostic studies. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist; however, review of submitted medical reports have not adequately demonstrated the indication for the MRI with exam findings only indicating tenderness without instability or neurological deficits. When the neurologic examination is less clear, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Based on the records reviewed and the guidelines, this request is not medically necessary and appropriate.