

Case Number:	CM15-0017770		
Date Assigned:	02/05/2015	Date of Injury:	04/27/2012
Decision Date:	04/02/2015	UR Denial Date:	01/14/2015
Priority:	Standard	Application Received:	01/30/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 53 year old female, who sustained an industrial injury on April 27, 2012. She has reported a trolley frame fell on her right foot, and in the process she twisted her left shoulder. The diagnoses have included status post left shoulder injury with complex regional pain syndrome (CRPS) of the left upper extremity. Treatment to date has included splinting, physical therapy, left shoulder injection, acupuncture, bracing, and medications. Currently, the injured worker complains of left hand and wrist stiffness, sensitivity, and pain. The Treating Physician's report dated January 5, 2015, noted the injured worker was scheduled for surgery for the left shoulder but it was held off due to left hand and wrist issues. Physical examination of the left upper extremity was noted to show clawing of the left ring and little finger, mild to moderate diffuse swelling of the left hand and wrist, mild diffuse tenderness of the left hand and wrist, and diminished sensation to all fingers of the left hand with normal sensation of the left thumb. X-rays of the left hand and wrist were noted to show generalized osteopenia spur at the ulnar base of the proximal phalanx left thumb, a small spur at the base of the left fifth metacarpal metaphyseal region, and flexion deformity of the left little finger. On January 14, 2015, Utilization Review non-certified a MRI left hand with and without contrast, a MRI left wrist with and without contrast, occupational therapy with evaluation and treatment 3x4 to the left shoulder and left hand/wrist, and pain management consult for the left upper extremity, noting there was no evidence of injury to the left hand or wrist to justify left hand wrist and hand MRIs with and without contrast, there was no report from previous therapy, and there was no medical rationale provided for a pain management consultation. The MTUS American College of Occupational

and Environmental Medicine (ACOEM) Guidelines and the MTUS Chronic Pain Medical Treatment Guidelines were cited. On January 30, 2015, the injured worker submitted an application for IMR for review of a MRI left hand with and without contrast, a MRI left wrist with and without contrast, occupational therapy with evaluation and treatment 3x4 to the left shoulder and left hand/wrist, and pain management consult for the left upper extremity.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI left hand with and without contrast: Upheld

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

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

Decision rationale: 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. o 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, the presumptive diagnosis is reflex sympathetic dystrophy affecting the left upper extremity. The diagnosis of complex regional pain syndrome type I is based upon clinical symptoms, with adjunctive testing such as with a bone scan. It is not evident how an MRI would benefit this situation given that x-rays are ready demonstrate osteopenia. Furthermore, industrial causation has not been clearly established. It is beyond the scope of the independent medical review process to establish causation. This can be established through a panel qualified medical evaluation. It is noted that the initial injury only involve the left shoulder, and the requesting provider asserts that the left wrist and hand issues are secondary to the left shoulder injury. This request is not medically necessary at this time.

MRI left wrist with and without contrast: Upheld

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

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

Decision rationale: 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 follow-up 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, the presumptive diagnosis is reflex sympathetic dystrophy affecting the left upper extremity. The diagnosis of complex regional pain syndrome type I is based upon clinical symptoms, with adjunctive testing such as with a bone scan. It is not evident how an MRI would benefit this situation given that x-rays are ready demonstrate osteopenia. Furthermore, industrial causation has not been clearly established. It is beyond the scope of the independent medical review process to establish causation. This can be established through a panel qualified medical evaluation. It is noted that the initial injury only involve the left shoulder, and the requesting provider asserts that the left wrist and hand issues are secondary to the left shoulder injury. This request is not medically necessary at this time.

Occupational therapy with evaluation and treatment 3x4 to the left shoulder and left hand/wrist: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine 99.

Decision rationale: Physical therapy is recommended per the California Medical Treatment Utilization Schedule as a first line option. However, in this case, industrial causation has not been clearly established. It is beyond the scope of the independent medical review process to establish causation. This can be established through a panel qualified medical evaluation. It is noted that the initial injury only involve the left shoulder, and the requesting provider asserts that the left wrist and hand issues are secondary to the shoulder injury. This request is not medically necessary at this time until clarification of industrial causation of the left CRPS is established.

Pain management consult for the left upper extremity: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 7- Independent Medical Examinations and Consultations, page 127, page 503.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation x American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Occupational Medicine Practice Guidelines, Independent Medical Examinations and Consultations Chapter, Page 127.

Decision rationale: With regard to the request for specialty consultation, the ACOEM Practice Guidelines recommend expert consultation when the plan or course of care may benefit from additional expertise. However, in this case, industrial causation has not been clearly established. It is beyond the scope of the independent medical review process to establish causation. This can be established through a panel qualified medical evaluation. It is noted that the initial injury only involve the left shoulder, and the requesting provider asserts that the left wrist and hand issues

are secondary to the shoulder injury. This request is not medically necessary at this time until clarification of industrial causation of the left CRPS is established.