

<b>Case Number:</b>	CM15-0163879		
<b>Date Assigned:</b>	09/01/2015	<b>Date of Injury:</b>	02/13/2012
<b>Decision Date:</b>	09/30/2015	<b>UR Denial Date:</b>	07/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/20/2015

### 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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive Medicine

### 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 36-year-old female, who sustained an industrial injury on 2-13-12. The injured worker has complaints of left shoulder pain and left wrist pain. Left shoulder examination reveals four healed arthroscopic portals and two of them have developed a keloid scar and the left trapezius and bicipital groove were tender to palpation. The diagnoses have included cumulative trauma disorder of bilateral upper extremities; bilateral shoulder impingement and chronic bilateral wrist pain. Treatment to date has included norco; left shoulder arthroscopic rotator cuff repair with subacromial decompression and acromioplasty and extensive debridement of the glenohumeral joint on 3-18-14; left wrist arthroscopic synovectomy, triangular fibrocartilage complex debridement, dorsal capsulectomy and ganglionectomy on 5-29-13 and magnetic resonance imaging (MRI) showed evidence of a full thickness tear of the volar component of the sacpholunate ligament with intact dorsal and membranous components, but without evidence of scapholunate instability. The request was for right wrist arthrogram and consult internal medicine. Several documents within the submitted medical records are difficult to decipher.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right wrist arthrogram:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist & Hand, Arthrography.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-272. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, wrist and Hand, Magnetic Resonance Imaging.

**Decision rationale:** ACOEM states, "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 snuffbox (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". ODG states for a wrist MRI "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". The treating physician has provided no evidence of red flag diagnosis and has not met the above ODG and ACOEM criteria for an MRI Of the wrist. As such, the request for Right wrist arthrogram is not medically necessary.

**Consult internal medicine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM page 127.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 33. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Office Visits.

**Decision rationale:** MTUS is silent specifically regarding Internal Medicine consultation. ODG states concerning office visits "Recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient

is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self-care as soon as clinically feasible". ACOEM states regarding assessments, "The content of focused examinations is determined by the presenting complaint and the area(s) and organ system(s) affected." Further writes that covered areas should include "Focused regional examination" and "Neurologic, ophthalmologic, or other specific screening". The treating physician does not document why an Internal Medicine consultation is being requested at this time and does not detail objective findings to support the request. Additionally, the treating physician does not indicate what questions are being asked of the Internal Medicine consultant. As such, the request for Consult internal medicine is not medically necessary at this time.