

Case Number:	CM15-0165477		
Date Assigned:	09/03/2015	Date of Injury:	09/05/2014
Decision Date:	10/06/2015	UR Denial Date:	07/30/2015
Priority:	Standard	Application Received:	08/24/2015

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: North Carolina
 Certification(s)/Specialty: Family Practice

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 29-year-old female, who sustained an industrial injury on September 5, 2014, incurring right hand and right wrist injuries. Magnetic Resonance Imaging performed in May, 2015, of the right wrist was unremarkable. Electromyography studies were normal. She was diagnosed with a right wrist strain and right hand strain. Treatment included bracing, paraffin wax treatments, pain medications, neuropathic medications, and neuropathic topical analgesic cream. Currently, the injured worker complained of increased right wrist pain radiating up the right arm with constant numbness and stiffness of the arm and shoulder. She noted painful range of motion of the right wrist. She was diagnosed with complex regional pain syndrome of the right upper extremity. The treatment plan that was requested for authorization included a Magnetic Resonance Imaging of the right hand and extracorporeal shock wave treatment for the right wrist and hand.

IMR ISSUES, DECISIONS AND RATIONALES

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

Magnetic resonance imaging (MRI) of the right hand: 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), Forearm, Wrist and Hand, MRIs.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 271-274.

Decision rationale: The ACOEM chapter on wrist and hand complaints and special diagnostic imaging Table 11-6 does not recommend MRI of the wrist/ hand except the case of carpal tunnel syndrome or suspected infection. There is no documentation of expected infection or carpal tunnel syndrome. Therefore, criteria set forth by the ACOEM for hand MRI have not been met and the request is not medically necessary.

Extracorporeal shock wave treatment once a week for 4 weeks for the right wrist/hand:
Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shockwave therapy.

Decision rationale: The California MTUS and the ACOEM do not specifically address the requested service. The ACEM chapter on wrist and hand complaints does not support shockwave therapy for the treatment of wrist or hand pain. Per the Official Disability Guidelines section on shockwave therapy: Not recommended, particularly using high energy ESWT. It is under study for low energy ESWT. The value, if any, for ESWT treatment of the elbow cannot be confirmed or excluded. Criteria for use of ESWT include: 1. Pain in the lateral elbow despite six months of therapy; 2. Three conservative therapies prior to ESWT have been tried prior; 3. No contraindications to therapy; 4. Maximum of 3 therapy sessions over 3 weeks. Criteria as outlined above have not been met and therefore the request is not medically necessary.