MAXIMUS Federal Services

Case Number:	CM15-0189008		
Date Assigned:	10/01/2015	Date of Injury:	03/19/2008
Decision Date:	11/25/2015	UR Denial Date:	08/25/2015
Priority:	Standard	Application Received:	09/25/2015

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, California
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 60 year old male, who sustained an industrial injury on 3-19-08. He reported pain in the left wrist and left arm. The injured worker was diagnosed as having synovitis or tenosynovitis, carpal tunnel syndrome and ulnar nerve lesion. Treatment to date has included left elbow surgery in 2011, left wrist surgery in 2010 and 2011, acupuncture, physical therapy, and medication including Norco. Physical examination findings on 5-27-15 included a weak left hand grip, decreased sensation in the left arm, and Tinel's sign was positive at bilateral wrists. A left elbow MRI obtained on 6-6-13 was noted to be normal. A MRI of the left wrist obtained on 7-9-13 revealed moderate degenerative changes of the first carpometacarpal joint with no focus of abnormal enhancement or other abnormality. On, 5-27-15 the injured worker complained of pain in the left elbow and bilateral wrists left greater than right. On 8-17-15, the treating physician requested authorization for a MRI of the left wrist and a MRI of the left elbow. On 8- 25-15 the requests were non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the left wrist #1: Overturned

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

MAXIMUS guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Initial Assessment, Diagnostic Criteria, Special Studies. 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 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. 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 evidence of red flag diagnosis and has met the above ODG and ACOEM criteria for an MRI Of the wrist. As such, the request for MRI of the left wrist #1 is medically necessary.

MRI of the left elbow #1: Overturned

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

MAXIMUS guideline: Decision based on MTUS Elbow Complaints 2007, Section(s): Recommendations, Summary. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow (Acute & Chronic), MRIs.

Decision rationale: ACOEM states, Criteria for ordering imaging studies are: The imaging study results will substantially change the treatment plan. Emergence of a red flag. Failure to progress in a rehabilitation program, evidence of significant tissue insult or neurological dysfunction that has been shown to be correctible by invasive treatment, and agreement by the patient to undergo invasive treatment if the presence of the correctible lesion is confirmed. For most patients presenting with elbow problems, special studies are not needed unless a period of at least 4 weeks of conservative care and observation fails to improve their symptoms. Most patients improve quickly, provided red flag conditions are ruled out. There are a few exceptions to the rule to avoid special studies absent red flags in the first month. These exceptions include:

Plain-film radiography to rule out osteomyelitis or joint effusion in cases of significant septic olecranon bursitis. Electromyography (EMG) study if cervical radiculopathy is suspected as a cause of lateral arm pain, and that condition has been present for at least 6 weeks. Nerve conduction study and possibly EMG if severe nerve entrapment is suspected on the basis of physical examination, denervation atrophy is likely, and there is a failure to respond to conservative treatment. For patients with limitations of activity after 4 weeks and unexplained physical findings such as effusion or localized pain (especially following exercise), imaging may be indicated to clarify the diagnosis and revise the treatment strategy if appropriate. Imaging findings should be correlated with physical findings. In general, an imaging study may be an appropriate consideration for a patient whose limitations due to consistent symptoms have persisted for 1 month or more, as in the following cases: When surgery is being considered for a specific anatomic defect to further evaluate potentially serious pathology, such as a possible tumor, when the clinical examination suggests the diagnosis. ACOEM further recommends MRI for suspected ulnar collateral ligament tears and recommends against MRI for suspected epicondylgia. ODG writes regarding elbow MRI, recommended as indicated below. Magnetic resonance imaging may provide important diagnostic information for evaluating the adult elbow in many different conditions, including: collateral ligament injury, epicondylitis, injury to the biceps and triceps tendons, abnormality of the ulnar, radial, or median nerve, and for masses about the elbow joint. There is a lack of studies showing the sensitivity and specificity of MR in many of these entities; most of the studies demonstrate MR findings in patients either known or highly likely to have a specific condition. Epicondylitis (lateral - "tennis elbow" or medial - in pitchers, golfers, and tennis players) is a common clinical diagnosis, and MRI is usually not necessary. Magnetic resonance may be useful for confirmation of the diagnosis in refractory cases and to exclude associated tendon and ligament tear. Indications for imaging Magnetic resonance imaging (MRI): Chronic elbow pain, suspect intra-articular osteocartilaginous body; plain films non-diagnostic; Chronic elbow pain, suspect occult injury; e.g., osteochondral injury; plain films non-diagnostic; Chronic elbow pain, suspect unstable osteochondral injury; plain films non-diagnostic; Chronic elbow pain, suspect nerve entrapment or mass; plain films non-diagnostic; Chronic elbow pain, suspect chronic epicondylitis; plain films non-diagnostic; Chronic elbow pain, suspect collateral ligament tear; plain films non-diagnostic; Chronic elbow pain, suspect biceps tendon tear and/or bursitis; plain films non-diagnostic. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. The medical records do indicate chronic elbow pain with a decrease in sensation in the left hand. There is a concern for ulnar nerve damage. As such, the request for MRI of the left elbow #1 is medically necessary.