

Case Number:	CM15-0035004		
Date Assigned:	03/03/2015	Date of Injury:	06/02/2014
Decision Date:	04/27/2015	UR Denial Date:	02/20/2015
Priority:	Standard	Application Received:	02/24/2015

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: New Jersey, New York
 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 47-year-old female, who sustained a work related injury on 6/2/14. The injury is accumulative trauma and repetitive strain injury. The diagnoses have included right wrist sprain/strain, right de Quervain's tenosynovitis and left thumb sprain/strain. Treatments to date have included oral medications, medicated creams, a nerve conduction study of bilateral upper extremities completed on 11/12/14, 12 sessions of physical therapy with minimal benefit, and x-rays of bilateral hands and wrists completed on 2/25/15. In the PR-2 dated 2/6/15, the injured worker complains of right hand and left thumb pain. She rates the pain an 8/10 on or off medications. She has tenderness to palpation over radial side of right wrist. Phalen's sign is negative. Tinel's sign is positive. She has enlargement of the metocarpophalangeal joint of left thumb. Finkelstein's test is negative. She has an enlarged metocarpophalangeal joint of right thumb. She has tenderness to palpation of right proximal interphalangeal joint of thumb. Finkelstein's test is positive. On 2/20/15, Utilization Review non-certified a request for a MRI of the right wrist. The California MTUS, Chronic Pain Treatment Guidelines, were cited. On 2/20/15, Utilization Review modified a request for x-rays of bilateral wrists and hands to 1 x-ray of right wrist and hand. The California MTUS, ACOEM Guidelines and ODG were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 X-ray of the bilateral wrists and hands: 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 rationale: The request is considered not medically necessary. The patient had already had x-rays of bilateral wrists and hands in 2/2015. There was no change in exam or symptoms that would require a repeat x-ray. Also, the right wrist had the majority of symptoms and exam findings that would warrant imaging. There was lack of documentation of significant exam findings of the left wrist and hand that would demonstrate severe pathology requiring an x-ray. Therefore, the request is considered not medically necessary as stated.

MRI (magnetic resonance imaging) of the right wrist: Overturned

Claims Administrator 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, and Hand, MRI's (magnetic resonance imaging).

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

Decision rationale: The request is considered medically necessary. The patient had unremarkable x-ray of the right wrist and normal electrodiagnostic studies but continues with a positive Tinel's and tender radial side and anatomical snuff box. According to ODG guidelines, chronic pain with negative imaging could potentially warrant an MRI. The patient has had conservative care including medications and physical therapy but still complains of pain. Therefore, I am reversing the UR decision and consider a right wrist MRI to be medically necessary.