

<b>Case Number:</b>	CM14-0141871		
<b>Date Assigned:</b>	09/10/2014	<b>Date of Injury:</b>	06/13/2008
<b>Decision Date:</b>	10/14/2014	<b>UR Denial Date:</b>	08/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/02/2014

### 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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

Patient is a 39 year-old female with date of injury 06/13/2008. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 08/13/2014, lists subjective complaints as severe left wrist pain. Objective findings: Patient's dystonia had improved, but there was residual left laterocollis. There was severe left shoulder tenderness and moderate right wrist pain with clicking. Severe lumbar spine discomfort and Final Determination Letter for IMR Case Number CM14-0141871 3 tenderness and limited range of motion. Diagnosis: 1. cervical dystonia 2. Complex regional pain syndrome 3. Left frozen shoulder 4. Post-traumatic stress 5. Sleep disturbance 6. Status post T7-T8 decompression with thoracic myelopathy 7. Lumbar spondylosis 8. Left pisiform syndrome 9. Idiopathic cyclic peripheral edema. Patient has had Botox injections as well as a deep brain stimulator implant for dystonia of her left neck musculature. She has a complex regional pain syndrome involving her left upper extremity and is status post ketamine infusion treatment. It has been noted that the patient has been becoming more depressed and paranoid recently, necessitating immediate intervention.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Testing: Other; Injection- right wrist Ultrasound:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, & Hand (Acute & Chronic), Ultrasound (diagnostic)

**Decision rationale:** The request is not for an injection of the wrist. The requesting physician has requested an ultrasound of the right wrist to rule out internal derangement and possible TFC tear with clicking and pain. Ultrasound is chosen for the study because the patient cannot undergo an MRI due to an implanted deep brain stimulator. The Official Disability Guidelines recommend ultrasound of the wrist. Ultra sonography is a dynamic process and is accurate in detecting tendon injuries. The ulnar nerve is also easily visualized. I am reversing the prior utilization review decision. Ultrasound of the right wrist is medically necessary.

**Testing: Other; Injection- repeat lumbar epidural palliative steroid injection:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines , Page(s): 46.

**Decision rationale:** According to the MTUS, several diagnostic criteria must be present to recommend an epidural steroid injection. The most important criteria are that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The medical record fails to document any of the above. Therefore the request is not medically necessary.