

<b>Case Number:</b>	CM15-0123607		
<b>Date Assigned:</b>	07/08/2015	<b>Date of Injury:</b>	01/14/2013
<b>Decision Date:</b>	08/11/2015	<b>UR Denial Date:</b>	06/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/26/2015

### 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: Arizona, Texas  
 Certification(s)/Specialty: Internal 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 46-year-old female, who sustained an industrial injury on 1/14/13. Initial complaints were she fell when a chair broke and landed on her back. The injured worker was diagnosed as having cervical spine disc bulges; thoracic spine strain; lumbar spine strain; right elbow strain; left elbow strain; right wrist and hand strain; contusion bilateral hips; moderate chondromalacia left knee; somatoform pain disorder; obesity. Treatment to date has included chiropractic therapy; acupuncture; physical therapy; medications. Diagnostics studies included MRI cervical spine (11/22/13); MRI lumbar spine (5/8/15); EMG/NCV study bilateral upper extremities (5/28/15). Currently, the PR-2 notes dated 5/6/15 is an Agreed Medical Reexamination. The notes indicated the injured worker complains of continued neck pain with pain radiating to the bilateral shoulders; occasional headaches; continuous bilateral shoulder pain, left greater than the right, with pain radiating to the bilateral upper arms; continuous bilateral elbow pain right greater than left with pain radiating to the forearms; continuous bilateral wrist and hand pain right greater than the left radiating to the fingers; continuous mid and low back pain with pain radiating to the bilateral hips and left greater than right; continuous bilateral hips pain with left greater than right; continuous left knee pain and intermittent right knee pain. The provider notes that the low back is the most bothersome area of her complaint. On physical examination the provider documents her gait is short strided heel toe gait and complains of inability to walk on heels and toes due to left knee will give out. The cervical spine notes tenderness of the midline, occiput and throughout the cervical spine. There are no spasms. There is tenderness of the left trapezius and over the bicipital groove. The lumbar spine notes tenderness, diffusely of the lumbar spine and bilateral lumbar paraspinal muscles with spasm. There is trace effusion or swelling of the left knee with tenderness over the left medial joint line. She has 0-100 degrees bilaterally with hip range of motion with pain in the back and lower extremities. On motor examination there is generalized weakness of the bilateral

upper extremities with poor effort. The provider reviewed x-rays of the cervical spine noting moderate disc degeneration at C5-6 and severe disc space narrowing at C6-7 and anterior spurring. The bilateral shoulder x-rays show narrowing of the acromioclavicular joints bilaterally. The thoracic spine x-rays report mild, generalized spondylosis throughout consistent with the injured worker's age and weight. The right elbow does not show any evidence of abnormal calcifications, and no significant degenerative changes. Bilateral hand x-rays are normal and negative for any recent or old fracture. The lumbar spine notes severe disc degeneration at L5-S1 with spondylosis at the lumbosacral level. There is a 2mm of retrolisthesis of L5 on S1. Bilateral hip x-rays are negative for any recent or old fracture and no obvious degenerative changes. The left knee x-ray notes narrowing of the medial compartment of about 3mm. The joint space remains on the weight bearing view with no fractures or abnormalities of soft tissue calcifications visualized. The injured worker recalls receiving a left knee injection without benefit and she also reports she has an epidural steroid injection in late 2013 to the cervical spine without improvement of her symptoms. She reports another injury on 12/2/14 running to catch a bus and slipped and fell landing on her left side. She noticed increased pain in her low back and left knee. A MRI of the lumbar spine dated 5/8/15 impression notes a 4mm central disk protrusion at L5-S1 with annular tear indenting the anterior thecal sac without evidence of significant canal stenosis. The facets joints are normal. At the L4-L5 level there is a 2mm broad-based disk bulge causing no significant neural foraminal narrowing or canal stenosis. There is a moderate bilateral hypertrophic facet degenerative change seen. At the L3-L4 level there is a 1-2mm bulge with no significant neural foraminal narrowing or canal stenosis. The EMG/NCV study of the upper extremities dated 5/28/15 notes an impression of mild bilateral median neuropathy at the wrist (carpal tunnel syndrome) and mild bilateral ulnar neuropathy across the elbows (cubital tunnel syndrome). The provider's treatment plan included x-rays of the left wrist.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Xrays of Left Wrist: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Forearm, Wrist & Hand - Indications for imaging - x-rays.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-269.

**Decision rationale:** 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. An acute injury to the metacarpophalangeal joint of the thumb, accompanied by tenderness on the ulnar side of the joint and laxity when that side of the joint is stressed (compared to the other side), may indicate a gamekeeper thumb or rupture of the ligament at that location. Radiographic films may show a fracture; stress views, if obtainable, may show laxity. The diagnosis may necessitate surgical repair of the ligament; therefore, a surgical referral is warranted. If symptoms have not resolved in four to six weeks and the patient has joint effusion,

serologic studies for Lyme disease and autoimmune diseases may be indicated. Imaging studies to clarify the diagnosis may be warranted if the medical history and physical examination suggest specific disorders. Table 11-6 provides a general comparison of the abilities of different imaging techniques to identify physiologic insult and define anatomic defects. In this case the patient has chronic wrist pain without any documentation of new injury or acute flare of pain. The medical necessity for an x-ray of the wrist is not made.