MAXIMUS Federal Services

| Case Number: | CM15-0091068 | | |
|---|---|---|---|
| Date Assigned: | 07/02/2015 | Date of Injury: | 03/05/2015 |
| Decision Date: | 08/25/2015 | UR Denial Date: | 04/27/2015 |
| Priority: | Standard | Application Received: | 05/11/2015 |

## 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: California
Certification(s)/Specialty: Preventive Medicine, Occupational 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 58-year-old female who sustained an industrial injury on 3/5/15 when she was punching down on a lever to squeeze out a mop her hand slipped causing her to hyperextend her right wrist and thumb on the edge of the lever resulting in right wrist and hand pain. She was medically evaluated, x-rayed and placed on modified duty. She currently complains of worsening right wrist and hand pain. On physical exam of the right hand there were degenerative changes, mild swelling of the digits, tenderness to palpation of the thumb with decreased range of motion; right wrist revealed degenerative changes, swelling and tenderness on palpation with decreased range of motion. Medications were tramadol, nabumetone. Diagnoses include right wrist strain; right hand/ finger strain. Treatments to date include right wrist support; medications. Diagnostics included x-rays wrist (3/5/15); x-ray of the right shoulder (4/27/15) showing mild degenerative changes; x-ray of the right wrist (4/27/15) showing a compressed nondisplaced fracture in the distal radius. On 4/27/15, Utilization Review evaluated requests for MRI of the right shoulder; electromyography/ nerve conduction velocity of bilateral upper extremities; chiropractic/ physiotherapy.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI (magnetic resonance imaging) right shoulder;:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

**Decision rationale:** Per the MTUS Guidelines, the criteria for ordering imaging studies of the shoulder include emergence of a red flag, physiologic evidence of tissue insult or neurovascular dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. The clinical documents provided do not indicate that any of these criteria are met. The requesting provider does not document reasoning to support a request for MRI outside these guideline recommendations. The request for MRI (magnetic resonance imaging) right shoulder is determined to not be medically necessary.

**EMG/NCV (electromyographynerve conduction studies) bilateral upper extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

**Decision rationale:** The MTUS Guidelines state that unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to order imaging studies if symptoms persist. When neurologic examination is less clear, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. EMG and NCV may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. In this case, there are no left sided complaints. Right-sided complaints do not provide strong evidence of neurovascular compromise; therefore, the request for EMG/NCV (electromyographynerve conduction studies) bilateral upper extremities is determined to not be medically necessary.

**Chiropractic /Physiotherapy:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & Manipulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Section Page(s): 58-61.

**Decision rationale:** Per the MTUS Guidelines, chiropractic care consisting of manual therapy and manipulation for the low back is recommended for chronic pain if caused by musculoskeletal conditions. Manual therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's

therapeutic exercise program and return to productive activities. A therapeutic trial of 6 visits over 2 weeks is recommended. If there is evidence of objective functional improvement, a total of 18 visits over 6 to 8 weeks is recommended. Elective or maintenance care is not recommended. Recurrences or flare-ups should be evaluated for treatment success, and if return to work is achieved, 1-2 visits every 4-6 months is reasonable. The request for Chiropractic /Physiotherapy is determined to not be medically necessary. In this case, the injured worker has previously participated in 6 chiropractic sessions without documented improvement in function. Additionally, the number of visits needed is not included with this request. The request for chiropractic/physiotherapy is determined to not be medically necessary.