

Case Number:	CM15-0093831		
Date Assigned:	05/20/2015	Date of Injury:	08/16/2013
Decision Date:	06/19/2015	UR Denial Date:	04/23/2015
Priority:	Standard	Application Received:	05/15/2015

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: Emergency 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 57 year old male, who sustained an industrial injury on 08/16/2013. He reported sustaining injuries to his right hand during the course of his employment. The injured worker is currently on modified duty. The injured worker is currently diagnosed as having wrist sprain, rotator cuff sprain, shoulder tendinitis, pain in wrist, and upper gastrointestinal hemorrhage. Treatment and diagnostics to date has included chiropractic treatment with excellent relief, urine drug screen, and medications. In a progress note dated 04/04/2015, the injured worker presented with complaints of right shoulder and right wrist/hand pain, rating his pain at a 6 out of 10. Objective findings include limited range of motion to the right shoulder and right wrist with tenderness to palpation. The treating physician reported requesting authorization for right hand MRI and physical therapy for the right hand.

IMR ISSUES, DECISIONS AND RATIONALES

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

Magnetic Resonance Imaging (MRI) of the right hand: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 258-260. Decision based on Non-MTUS Citation Official Disability Guidelines, Forearm, Wrist, & Hand (Acute & Chronic), MRI (Magnetic Resonance Imaging).

Decision rationale: The requested Magnetic Resonance Imaging (MRI) of the right hand is not medically necessary. American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 11, Forearm, Wrist and Hand Complaints, Diagnostic Criteria, Pages 258-260; and Official Disability Guidelines, Forearm, Wrist, & Hand (Acute & Chronic), MRI (Magnetic Resonance Imaging) recommend imaging studies with documented red flag conditions after failed conservative treatments. The injured worker has right shoulder and right wrist/hand pain, rating his pain at a 6 out of 10. Objective findings include limited range of motion to the right shoulder and right wrist with tenderness to palpation. The treating physician has not documented physical exam evidence indicative of unresolved red flag conditions nor notation that the imaging study results will substantially change the treatment plan. The criteria noted above not having been met, the requested Magnetic Resonance Imaging (MRI) of the right hand is not medically necessary.

Physical therapy 2 times a week for 10 weeks right hand: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine guidelines Page(s): 99.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 264-265. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist and Hand (Acute & Chronic), Physical Therapy.

Decision rationale: The requested Physical therapy 2 times a week for 10 weeks right hand is not medically necessary. American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 11, Forearm, Wrist and Hand Complaints, Physical Methods, Pages 264-265 and Official Disability Guidelines (ODG), Forearm, Wrist and Hand (Acute & Chronic), Physical Therapy, recommend continued physical therapy with documented objective evidence of derived functional improvement from completed physical therapy sessions as a transition to a dynamic home exercise program. The injured worker has right shoulder and right wrist/hand pain, rating his pain at a 6 out of 10. Objective findings include limited range of motion to the right shoulder and right wrist with tenderness to palpation. The treating physician has not documented objective evidence of derived functional improvement from completed physical therapy sessions, or the medical necessity for additional physical therapy beyond 4 to 6 sessions to accomplish a transition to a dynamic home exercise program. The criteria noted above not having been met, the requested Physical therapy 2 times a week for 10 weeks right hand is not medically necessary.