

<b>Case Number:</b>	CM15-0094784		
<b>Date Assigned:</b>	05/21/2015	<b>Date of Injury:</b>	05/23/2014
<b>Decision Date:</b>	07/15/2015	<b>UR Denial Date:</b>	05/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/18/2015

### 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: Physical Medicine & Rehabilitation, Pain Management

### CLINICAL CASE SUMMARY

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

This is a 53 year old male with a May 23, 2014 date of injury. A progress note dated January 20, 2015 documents subjective findings (headaches rated at a level of 4-5/10; radicular neck pain and muscle spasms rated at a level of 4-5/10; numbness and tingling of the bilateral upper extremities; left elbow pain and muscle spasms rated at a level of 4-5/20; weakness, numbness, tingling and pain radiating to the hand and fingers; residual left wrist and hand pain following fracture of the left wrist rated at a level of 4-5/10; radicular lower back pain and muscle spasms rated at a level of 4-5/10; numbness and tingling of the bilateral lower extremities), objective findings (tenderness to palpation along the cervical paraspinal muscles; decreased range of motion of the cervical spine; palpable tenderness over the left medial and lateral epicondyle; tenderness to palpation at the olecranon; pain with range of motion of the left elbow; tenderness to palpation noted over the distal left radius and over the articulation of the radius and carpus; tenderness to palpation is noted over the first carpometacarpal joint; generalized tenderness at the fourth and fifth digit; decreased range of motion of the left wrist; diminished sensation to pinprick and light touch over the C5, C6, C7, C8, and T1 dermatomes in the left upper extremity; decreased motor strength of the left upper extremity), and current diagnoses (cervical spine radiculopathy; cervical disc displacement; left elbow sprain/strain; left wrist sprain/strain; left wrist scapholunate ligament tear; left wrist subchondral cyst; status post closed left wrist fracture; left hand/fingers pain; status post closed left hand fracture). Treatments to date have included medications, physical therapy, and imaging studies. The medical record identifies that medications offer temporary relief of pain and improve ability to have restful sleep. The treating physician documented a plan of care that included a magnetic resonance imaging of the left wrist.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Retro repeat MRI of left wrist 2/4/15: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 269. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, and Hand and Carpal Tunnel Syndrome Chapters.

**Decision rationale:** Regarding the request for repeat MRI of wrist, the ODG Forearm, Wrist and Hand Chapter specify that repeat MRI is "not routinely recommended" but should be reserved for cases in which a significant change in pathology has occurred. The CA MTUS does not directly address the issue of repeat imaging, but the ACOEM Chapter 11 on pages 268-269 state the following regarding wrist/hand imaging studies: 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. In cases of peripheral nerve impingement, if no improvement or worsening has occurred within four to six weeks, electrical studies may be indicated. The primary treating physician may refer for a local lidocaine injection with or without corticosteroids. Recurrence of a symptomatic ganglion that has been previously aspirated or a trigger finger that has been previously treated with local injections (see Table 11-4) is usually an indication for re-aspiration or referral, based on the treating physician's judgment. A number of patients with hand and wrist complaints will have associated disease such as diabetes, hypothyroidism, Vitamin B complex deficiency and arthritis. When history indicates, testing for these or other comorbid conditions is recommended. 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. Within the documentation available for review, there is documentation of a prior wrist MRI performed on 7/21/14. A repeat MRI on 2/4/15 has taken place is the issue of controversy. A review of the documentation circa the timing of the second MRI fail to reveal significant changes in pathology or physical examination. No interim re-injury is noted. Given this, the request is not medically necessary.