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| <b>Case Number:</b>   | CM15-0098911 |                              |            |
| <b>Date Assigned:</b> | 06/01/2015   | <b>Date of Injury:</b>       | 02/27/2010 |
| <b>Decision Date:</b> | 07/01/2015   | <b>UR Denial Date:</b>       | 05/12/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 05/22/2015 |

### 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: New Jersey, New York  
 Certification(s)/Specialty: Family Practice

### 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 41 year old male, who sustained an industrial injury on February 27, 2010. He was diagnosed with a closed head injury, distal radius fracture and ulnar fracture, right shoulder strain and lumbar disc disease after a fall. He underwent an open reduction and internal fixation of the radius and ulnar fracture. Electromyography studies were unremarkable. Magnetic Resonance Imaging of the lumbar spine revealed lumbar stenosis. Treatment included work restrictions, assistive devices for mobility, and pain management. Currently, the injured worker complained of constant burning pain with cramping spasms and stiffness in his right wrist and hand radiating, into his arm. He complained of weakness in his arm and hand and lower back radiating into his groin and buttocks and down into his legs and feet. The treatment plan that was requested for authorization included a retrospective request of Magnetic Resonance Imaging of the right wrist with Arthrogram with a date of service of March 9, 2012.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective request: MRI of the right wrist with arthrogram DOS 03/09/2012:** 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): 268-269. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Wrist/Hand MRI.

**Decision rationale:** The request is considered not medically necessary. As per MTUS guidelines, the patient does not need special studies until after a 4-6 week period of failed conservative care and there are no red flags or exceptions as stated in the MTUS. The patient had received chiropractic care but improvement in pain and function or lack of improvement was not documented. Therefore, it cannot be stated that he failed conservative therapy. There was no indication for an MRI at the time, therefore, the request is considered not medically necessary.