

<b>Case Number:</b>	CM14-0146200		
<b>Date Assigned:</b>	09/12/2014	<b>Date of Injury:</b>	07/05/2012
<b>Decision Date:</b>	10/06/2014	<b>UR Denial Date:</b>	08/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/09/2014

### 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. The expert reviewer is Board Certified in Plastic and Reconstructive Surgery and is licensed to practice in Maryland, Virginia, and North Carolina. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 32 year old male with a reported date of injury on 7/5/12 who requested authorization for bone scan of the left wrist. Progress report dated 8/18/14 is partially illegible and notes that the patient complains of persistent left elbow and wrist pain and difficulty with use. Examination notes left wrist tender to palpation at the medial aspect and ulnar styloid. Diagnosis is stated as left wrist strain and full-thickness triangular fibrocartilage tear of the radial attachment, moderate diffuse tearing of the ulnar styloid attachment, focal tearing of the ulnar foveal attachment extending into the dorsal radioulnar ligament of the left wrist. Plan is for awaiting report from hand specialist for possible surgery, continue Motrin and PPI for GI upset. RFA dated 8/14/14 notes request for bone scan of the left hand with diagnoses of TFCC left hand and strain of the left wrist. Documentation from hand surgery report dated 8/6/14 notes a review of previous evaluations and diagnostic studies. He states, 'In conclusion, there is no objective data in the physical examination or the MRIs or bone scan to definitively diagnose an ECU problem or treatable TFCC problem or to explain his radial or dorsal wrist symptoms or to explain the ulnar hand or thenar symptoms.' He further states, 'To be complete with regard to evaluating (the patient's) wrist, selective Xylocaine/Marcaine with or without cortisone injections might possibly help elucidate an anatomic treatable cause for his ulnar wrist symptoms, if indeed there is one. Progress report dated 7/21/14 notes the patient is complaining of left wrist and hand pain with numbness and difficulty with use. The patient is not working and is using Motrin. Examination notes tenderness to palpation of the left wrist and elbow and positive Tinel's of the left wrist and elbow. Strength is 5/5. Plan is for follow-up with hand specialist for possible surgery, continue meds, TTD, and follow up in one month. Progress report from evaluation dated 5/19/14 notes pain of the left wrist and elbow and difficulties with use. Examination notes range-of-motion of the left wrist with pain at ulnar deviation at end range. There is positive

crepitus and popping with range of motion of the left wrist, specifically at the triangular fibrocartilage. There is positive Tinel's at the left wrist and elbow. MRI of the left wrist from 10/19/12 and 11/17/13 is noted as well as bone scan of the left wrist and hand from 2/20/14(all reviewed previously). Plan is for Prilosec for GI symptoms, follow-up with hand specialist, solar care heating pad and follow-up in one month. Documentation from the hand specialist on 4/29/14 notes an assessment of pain in the ulnar sensory nerve of the left hand, wrist and distal forearm, electrodiagnostically slightly positive left ulnar nerve entrapment, normal bone scan, MRI suggestion of radial perforation of the TFCC, subluxation of the left ECU tendon and high range of perceived upper extremity dysfunction. Plan is for review of the MRIs to look specifically at the ECU. Progress report from evaluation on 4/21/14 notes the patient complains of burning pain of the left wrist with associated numbness. Results from a bone scan of the left wrist/hand on 2/20/14 are stated as: '1) Fairly unremarkable limited three phase bone imaging study with no obvious focal findings. 2) Minimal arthritic changes may be seen in the left radial carpal joint.' Examination documents tenderness of the TFCC at the left wrist, positive crepitation and clicking sign, range of motion is near normal with pain at end range of wrist and tenderness of the medial epicondyle of the left elbow. Plan is to continue Motrin, Prilosec for GI symptoms, TENS unit, follow-up with hand specialist, solar care heating pad and follow-up in one month. Progress report dated 3/17/14 notes left hand/wrist/elbow burning pain. Plan is stated as awaiting bone scan, refill of Motrin and follow-up in one month. Bone scan report dated 2/20/14 notes '1) Fairly unremarkable limited three phase bone imaging study with no obvious focal findings. 2) Minimal arthritic changes may be seen in the left radial carpal joint. 'Progress report from evaluation on 12/16/13 notes patient has a consultation pending with a hand specialist. The patient complains of left hand/wrist burning pain with numbness in the fingers that is unchanged. A previous MRI examination is noted. The patient takes Motrin. Examination notes an increase in range of motion of the wrist. Diagnosis is stated as full-thickness triangular fibrocartilage perforation of the left wrist, full-thickness tear of the radial attachment, diffuse tearing of the ulnar styloid attachment, partial focal tear of the ulnar fovea attachment extending into the dorsal radioulnar ligament, MRI(10/19/12) and left wrist strain. MRI results from 11/17/13 were not available. Plan is for continued hand therapy. Progress report from evaluation on 10/23/13 notes the patient complains of left hand/wrist burning pain with numbness in the fingers that affects his function. He continues taking Motrin. A previous MRI examination is noted. Examination notes range of motion of the left wrist is reduced. Diagnosis is stated as full-thickness triangular fibrocartilage perforation of the left wrist, full-thickness tear of the radial attachment, diffuse tearing of the ulnar styloid attachment, partial focal tear of the ulnar fovea attachment extending into the dorsal radioulnar ligament, MRI (10/19/12) and left wrist strain. Plan is for continued hand therapy, hand specialist, continued Motrin and wrist bracing. Utilization review dated 8/21/14 did not certify the bone scan noting that 'there is no clear rationale for the request'. A previous bone scan was performed on 2/20/14 without documentation of the results. 'It is unclear why the claimant needs another bone scan.'

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

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

**Bone scan for the left wrist bone:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment in Workers Compensation (TWC), Pain Procedure Summary, last updated 07/10/2014

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Complex Regional Pain Syndrome (CRPS) CRPS, diagnostic criteria Page(s): 36-37.

**Decision rationale:** 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. There is no indication that this is presently suspected. A bone scan may be indicated in the work-up of Complex Regional Pain Syndrome (CRPS). From page 36 of Chronic Pain Medical Treatment Guidelines, CRPS, diagnostic criteria: The Washington State Department of Labor and Industries guidelines include the presence of four of the following physical findings: (1) Vasomotor changes: temperature/color change; (2) Edema; (3) Trophic changes: skin, hair, and/or nail growth abnormalities; (4) Impaired motor function (tremor, abnormal limb positioning and/or diffuse weakness that can't be explained by neuralgic loss or musculoskeletal dysfunction); (5) Hyperpathia/allodynia; or (6) Sudomotor changes: sweating. Diagnostic tests (only needed if four physical findings were not present): 3-phase bone scan that is abnormal in pattern characteristics for CRPS. (Washington, 2002) The State of Colorado Division of Workers' Compensation Medical Treatment Guidelines adopted the following diagnostic criteria in 2006: (1) The patient complains of pain (usually diffuse burning or aching); (2) Physical findings of at least vasomotor and/or sudomotor signs, allodynia and/or trophic findings add strength to the diagnosis; (3) At least two diagnostic testing procedures are positive and these procedures include the following: (a) Diagnostic imaging: Plain film radiography/triple phase bone scan, (b) Injections: Diagnostic sympathetic blocks, (c) Thermography: Cold water stress test/warm water stress test, or (d) Autonomic Test Battery. The authors provide the following caveat: Even the most sensitive tests can have false negatives, and the patient can still have CRPS-I, if clinical signs are strongly present. In patients with continued signs and symptoms of CRPS-I, further diagnostic testing may be appropriate. (Colorado, 2006) Again, the patient was noted to have a previous relatively normal scan and no further justification was provided for an additional scan. This is consistent with the findings of the utilization review. Treatment is not medically necessary and appropriate.

