MAXIMUS Federal Services

Case Number:	CM14-0177135		
Date Assigned:	10/30/2014	Date of Injury:	10/03/2012
Decision Date:	12/10/2014	UR Denial Date:	10/01/2014
Priority:	Standard	Application Received:	10/27/2014

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 Occupational Medicine and is licensed to practice in California. 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:

Medical records from 2014 were reviewed. The patient complained of left hand/wrist pain with numbness in the medial, ring, and small fingers. She likewise complained of popping sensation and stiffness at the wrist. Physical exam showed no gross deformity or swelling of the left wrist. Range of motion of the left wrist towards flexion and extension was measured at 10. Diffuse tenderness was noted at the left wrist. No instability was noted. Tinel sign over the volar surface of the wrist was unremarkable. There was mild flattening of the hyperthenar eminence. Range of motion of the left MCP, PIP, and DIP was limited. Middle, ring, and small fingers were held with the PIP joints rigidly flexed beyond 90 degrees. MCP joints were flexed to 50 degrees. No active motion was noted in these digits. Severe pain was noted with any attempt to extend the joint. Brisk capillary refill to the tips was noted. Sensation was intact. An MRI of the left wrist from 4/26/2013 showed subchondral cyst of the lunate. An X-ray of the left hand from 8/29/2014 showed diffuse osteopenia without bony abnormalities. Previous EMG showed cubital tunnel syndrome. Treatment to date has included physical therapy, use of a brace, activity restrictions, and medications. The present request for MRI of the left forearm is to evaluate for Volkmann's contracture. A utilization review from 10/01/2014 denied the request for MRI of the left forearm because it was unclear how MRI can change management/treatment for Volkmann contracture.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the left forearm: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist and Hand, MRI, Pain Chapter, CRPS

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist and Hand Section, Magnetic Resonance Imaging

Decision rationale: CA MTUS ACOEM Practice Guideline states that MRI of the wrist and hand is recommended to diagnose triangular fibrocartilage complex (TFCC) tears; for follow-up of select patients with crush injuries or compartment syndrome; to diagnose Kienbck disease; for diagnosis of occult scaphoid fracture when clinical suspicion remains high despite negative x-rays; and to diagnose suspected soft-tissue trauma after x-ray images confirm a complex displaced, unstable, or comminuted distal forearm fracture. Official Disability Guidelines state that MRI has been advocated for patients with chronic wrist pain because it enables clinicians to perform a global examination of the osseous and soft tissue structures. In this case, patient complained of left hand/wrist pain with numbness in the medial, ring, and small fingers. She likewise complained of popping sensation and stiffness at the wrist. Physical exam showed no gross deformity or swelling of the left wrist. Range of motion of the left wrist towards flexion and extension was measured at 10. Diffuse tenderness was noted at the left wrist. No instability was noted. Tinel sign over the volar surface of the wrist was unremarkable. There was mild flattening of the hyperthenar eminence. Range of motion of the left MCP, PIP, and DIP was limited. Middle, ring, and small fingers were held with the PIP joints rigidly flexed beyond 90 degrees. MCP joints were flexed to 50 degrees. No active motion was noted in these digits. Severe pain was noted with any attempt to extend the joint. Brisk capillary refill to the tips was noted. Sensation was intact. Symptoms persisted despite physical therapy, use of a brace, activity restrictions, and medications. The present request for MRI of the left forearm is to evaluate for Volkmann's contracture. Previous radiographic study showed subchondral cyst of the lunate per MRI of the left wrist from 4/26/2013. X-ray of the left hand from 8/29/2014 showed diffuse osteopenia without bony abnormalities. A previous EMG showed cubital tunnel syndrome. Given that patient had complex presentation of severe pain accompanied by contractures, performing MRI may be a reasonable diagnostic option. The current working impression of Volkmann contracture may be determined with radiographic imaging. Therefore, the request for MRI of left forearm is medically necessary.