Case Number:	CM14-0021266		
Date Assigned:	05/05/2014	**Date of Injury:**	07/24/2008
Decision Date:	07/25/2014	**UR Denial Date:**	02/10/2014
Priority:	Standard	**Application Received:**	02/20/2014

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:

Patient is a 57-year-old male who has submitted a claim for bilateral carpal tunnel syndrome status post release, and neuroma associated with an industrial injury date of 07/24/2008.Medical records from 2013 were reviewed. Patient complained of worsening pain at bilateral wrist and hand associated with weakness. Pain was described as burning in sensation. This resulted to difficulty performing lifting, carrying, gripping, grasping, holding, and manipulating objects. Physical examination showed diminished sensation and strength of 4/5 at bilateral ulnar nerve distribution. Jamar dynamometer readings showed 70-71-74 at left, and 62-63-68 at right. The median nerve distribution bilaterally likewise showed diminished sensation and strength of 3/5. Tinel's and Phalen's signs were positive bilaterally. Magnetic resonace imaging (MRI) of the right wrist from 04/15/2010 revealed non-visualization of portions of the flexor retinaculum compatible with the patient's history of previous carpal tunnel release surgery. There was apparent central perforation involving the triangular fibrocartilage. MRI of the right hand from 04/15/2010 revealed small area of metallic artifact either at the skin surface or within the subcutaneous soft tissues of the radial aspect of the index finger at the level of the middle phalanx. To correlate clinically these findings to rule out foreign body.Electrodiagnostic study from 01/06/2014 showed mild to moderate median nerve compromise at or near the carpal tunnel bilaterally. Treatment to date has included right carpal tunnel release surgery in 2009, use of a cock-up splint, physical therapy, acupuncture, and medications. Utilization review from 02/10/2014 denied the requests for MRI of the right hand and right wrist because there was no significant interval change in pathology.

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: Overturned

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.

Decision rationale: California Medical Treatment Utilization Schedule (MTUS) American College of Occupational and Environmental Medicine (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; to diagnose suspected soft-tissue trauma after x-ray images confirm a complex displaced, unstable, or comminuted distal forearm fracture. Official Disability Guidelines (ODG) states 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. The rationale for MRI is because patient's clinical manifestations are consistent with repetitive stress syndrome, carpal tunnel syndrome, and reflex sympathetic dystrophy. Patient had progressive worsening of right wrist / hand pain despite carpal tunnel release surgery. Objective findings showed diminished sensation and weakness of both ulnar and median nerve distributions. Last MRI was accomplished in 2010, and a repeat MRI at this time is reasonable given that patient presented with worsening manifestations. Guideline criteria were met. Therefore, the request for MRI of the right hand is medically necessary.

Magnetic resonance imaging (MRI) of the right wrist: Overturned

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.

Decision rationale: California Medical Treatment Utilization Schedule (MTUS) American College of Occupational and Environmental Medicine (ACOEM) Practice Guideline states that Magnetic resonance imaging (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; to diagnose suspected soft-tissue trauma after x-ray images confirm a complex displaced, unstable, or comminuted distal forearm fracture. Official Disability Guidelines (ODG) states 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. The rationale for MRI is because patient's clinical manifestations are consistent with repetitive stress syndrome, carpal tunnel syndrome, and reflex

sympathetic dystrophy. Patient had progressive worsening of right wrist / hand pain despite carpal tunnel release surgery. Objective findings showed diminished sensation and weakness of both ulnar and median nerve distributions. Last MRI was accomplished in 2010, and a repeat MRI at this time is reasonable given that patient presented with worsening manifestations. Guideline criteria were met. Therefore, the request for MRI of the right wrist is medically necessary.