

Case Number:	CM14-0065628		
Date Assigned:	07/11/2014	Date of Injury:	07/30/2007
Decision Date:	08/18/2014	UR Denial Date:	04/10/2014
Priority:	Standard	Application Received:	05/08/2014

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 Physical Medicine and Rehabilitation 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:

The injured worker is a 59-year-old male who reported an injury on 07/30/2007. The documentation indicated the injured worker underwent a carpal tunnel release on the right on 04/23/2013, and received a right ring finger steroid injection on 06/04/2013. Prior treatments included an epidural steroid injection, heat treatment, ice treatment, physical therapy, chiropractic care, and a TENS unit. The mechanism of injury was not provided. The documentation of 03/18/2014 revealed that the injured worker was guarding his right wrist. The treatment plan included an MRH of the right wrist. The physical examination was handwritten and difficult to read. The documentation on 03/12/2014 supplemental report revealed the injured worker had numbness in the right thumb. The physical examination revealed radial deviation of 15-20 and ulnar deviation of 25-30. That is a right/left wrist comparison. Extension of the wrists in the same manner were 55/55 and flexion 30/35. The physician documented there was not much resistance to the scaphoid shift test when evaluated on the right wrist. There was little resistance on the distal pole of the scaphoid on the right wrist. The x-ray of the right wrist revealed evidence of a previous fracture of the right radial metaphysis, healed with residual dorsal angulation of 10 degrees and dorsal angulation of the lunate of 22 degrees as well as a scapholunate angle of 80 degrees. Additionally, the rest of the x-ray was of poor fax quality and there was an inability to determine the rest of the x-ray examination note. There was a fluoroscopic evaluation of the right wrist with full passive hyperextension demonstrating a 5 mm diaphysis between the proximal pole of the scaphoid and the lunate during the extreme of right extension. The diagnoses included right median neuropathy secondary to compression of the carpal tunnel with previous preoperative evidence of axonometric injury, status post right carpal tunnel release 04/23/2013, left median neuropathy secondary to compression at the carpal tunnel preoperatively diagnosed with an axonometric injury, status post left carpal tunnel release on

06/04/2013, stenosing flexor tenosynovitis, right finger, status post steroid injection to the flexor sheath on 06/04/2013 and 07/22/2013 with slight triggering phenomenon, postoperative development of stenosing flexor tenosynovitis of the right little finger and left long finger with active triggering and left ring finger with triggering. Additionally, the documentation indicated diagnoses included blunt trauma to the right wrist occurring on 04/21/2012 with resultant fracture of the right radial metaphysis and the right ulnar styloid with evidence of interval union, demonstrating a loss of the volar tilt of the radial metaphysis with a resting dorsal angulation on the radial metaphysis at the radial carpal joint and with abnormal radial lunate and scapholunate angles with a dynamic diaphysis at the scapholunate articulation under fluoroscopy, which were noted to be consistent with a tear of the scapholunate interosseous ligament. There was a dynamic diaphysis, right scapholunate articulation with possible full thickness tear of the scapholunate interosseous ligament. The treatment plan included if the MR arthrogram failed to identify a tear of the scapholunate interosseous ligament, the injured worker would be scheduled for a mid carpal injection, as more than 50% of the time the physician opined that the mid carpal contrast study identified a tear which failed to be identified with a simple MR arthrogram. This request was previously denied as an imaging study as there was no evidence of a prior ambiguous electrodiagnostic study. Additionally, there was a lack of documentation of a legible physical examination. The subsequent documentation provided documentation of a legible examination, which supported the necessity for 1 MR arthrogram of the right wrist.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 MR Arthrogram of the Right Wrist: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): Table 11 - 7. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment for Workers' Compensation, Online Edition Chapter: Forearm, Wrist & Hand.

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 & Hand Chapter, MRI.

Decision rationale: The ACOEM Guidelines indicate for most injured workers presenting with true hand and wrist problems, special studies are not needed until after a 4-6 week period of conservative care and observation. However, they do not specifically address an MR arthrogram. As such, secondary guidelines were sought. The Official Disability Guidelines indicate that magnetic resonance imaging has been advocated for injured workers with chronic wrist pain, and it may be diagnostic in injured workers with triangular fibrocartilage and interosseous ligament tears, occult fractures, avascular necrosis, and miscellaneous other abnormalities. The clinical documentation submitted for review indicated the physician had a suspicion of a tear. The physical examination supported the request. This request would be supported. Given the above, the request for MR arthrogram of the right wrist is medically necessary.