

Case Number:	CM14-0175060		
Date Assigned:	12/12/2014	Date of Injury:	04/30/2001
Decision Date:	01/15/2015	UR Denial Date:	10/13/2014
Priority:	Standard	Application Received:	10/22/2014

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 57 year old female with a reported date of injury on 4/30/01 who requested an MRI of the bilateral hand/wrist, left De Quervain's release and pre-operative medical clearance. The patient had previously undergone right long finger trigger release and release of the second and third dorsal compartments with excision of osteophyte on 8/24/10. AME dated 9/4/13 notes bilateral wrist pain with a history of bilateral carpal tunnel release, as well as right long finger trigger release, right DeQuervain's release and release of the right 2nd and 3rd dorsal compartments. Her condition is noted to be permanent and stationary. Progress report dated 5/14/14 notes hands are having more pain and swelling. Left hand has tenderness and cramping. Pain interferes with sleep. X-rays of the left wrist are stated to show no acute changes. Examination notes no acute lymphatic changes with tender 1st dorsal compartment on the left, and no gross instability, no acute neuro changes and no evidence of infection. Recommendation is for MRI of the bilateral hand/wrist to rule out internal derangement, left De Quervain's release and pre-operative medical clearance, as well as physical therapy 3 times per week for 6 weeks. Progress report dated 6/16/14 notes that the left hand has pain and sharp shooting pains and interferes with sleep. Right hand has occasional pain. Examination notes no acute neuro changes, tender 1st dorsal compartment and no gross instability. Plan is for Tylenol, Aleve and home exercises as directed, as well as to request Left De Quervain's release, pre-op medical clearance, MRI of the bilateral wrist to rule out internal derangement and physical therapy 3 times per week for 6 weeks. Progress report dated 8/1/14 notes that the left hand pain interferes with sleep and has weakness. Right hand is doing ok but with occasional pain with activities. Examination notes no acute neuro changes, tender 1st dorsal compartment and no gross instability. Plan is to request Left De Quervain's release, pre-op medical clearance, MRI of the bilateral wrist to rule out internal derangement and physical therapy 3 times per week for 6

weeks. AME dated 8/8/14 notes the patient complains of left thumb CMC pain, as well as weakness and fatigue in the left hand. Her pain is described as mild and she does not have any difficulty sleeping. Examination notes normal range of motion of the wrists and tenderness over the left thumb CMC joint. Assessment is that the left wrist symptoms have worsened but could not recommend medical treatment until X-rays have been reviewed and more recent medical documentation. It is felt that the patient has reached maximal medical improvement on the right side. UR dated 8/11/14 certified physical therapy 3 x 6 and MRI of the bilateral wrists. Physical therapy documentation from 9/5/14 notes problem summary of pain, decreased grip strength and decreased functional activity. Plan is for physical therapy and initiation of a home exercise program. Hand therapy notes are provided through 11/17/14. Progress report dated 9/17/14 notes pain interferes with sleep and bad enough for surgery. She has pain and swelling. Examination notes no acute neuro changes, tender 1st dorsal compartment and no gross instability. Plan is for Tylenol, Aleve and Left De Quervain's release, pre-op medical clearance, and physical therapy 3 times per week for 6 weeks. RFA dated 10/9/14 requests physical therapy 3 x 6. Progress report dated 10/31/14 notes left hand interferes with sleep and bad enough for surgery and has numbness. Right hand has flared up due to weather changes. Examination notes no acute neuro changes, tender 1st dorsal compartment and no gross instability. Plan is for Tylenol, home exercises and Left De Quervain's release with excision of mass, pre-op medical clearance, and physical therapy 3 times per week for 6 weeks. Progress report dated 11/14/14 notes left wrist pain interferes with sleep and bad enough for surgery. She has numbness, pain and stiffness. Examination notes no acute neuro changes, tender 1st dorsal compartment and no gross instability. Plan is for home exercises, left De Quervain's release with excision of mass, pre-op medical clearance, and physical therapy 3 times per week for 6 weeks. Progress report dated 12/8/14 notes left wrist pain interferes with sleep and bad enough for surgery. Right hand has good and bad days with occasional stiffness. Pain in hands radiates up to the neck. Examination notes no acute neuro changes, tender 1st dorsal compartment and no gross instability. Plan is for home exercises, left De Quervain's release with excision of mass, pre-op medical clearance, and physical therapy 3 times per week for 6 weeks. UR dated 10/13/14 did not certify the requests for MRI of the bilateral hand/wrist, left De Quervain's release, pre-operative medical clearance and 18 physical therapy visits. With respect to the MRI of the bilateral wrists, previous x-rays indicated no acute changes and that there was no evidence to suggest a re-aggravation or new injury. With respect to De Quervain's release, the patient is noted to have undergone 7 physical therapy visits during September 2014 with reports of occasional wrist symptoms. Thus, release is not indicated.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI bilateral /hand/wrist: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- MRI

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist and Hand, Radiography, MRI

Decision rationale: The patient is a 57 year old female with documented chronic pain of the left wrist who had been undergoing physical therapy. There has been minimal documentation with respect to the right wrist to warrant an MRI evaluation. She had been noted to be permanent and stationary on the most recent AME with respect to the right wrist. There has been insufficient documentation to suggest a new injury or a re-aggravation to warrant further study. The only recent documentation has been that the right hand has flared up due to weather changes. No further specifics are provided and no specific, relevant examination of the right wrist is provided to evaluate the condition. With respect to the left wrist, the patient does have evidence of chronic pain and may require further radiographic evaluation. From ODG, specific indications for evaluation of chronic pain are as follow: - Chronic wrist pain, plain films normal, suspect soft tissue tumor- Chronic wrist pain, plain film normal or equivocal, suspect Kienbock's disease. However, as suggested by the AME, plain X-rays need to be evaluated prior to further medical treatment. The requesting surgeon only states that there were no acute changes on left wrist x-ray. More detail with respect to this evaluation is necessary to define the current status of the wrist and the thumb CMC (carpometacarpal) joint, as the examination of the AME points towards possible left thumb CMC joint arthritis. There is not sufficient evidence to suggest a soft tissue tumor or Kienbock's disease. Additionally, a complete, detailed examination of the left wrist has not been provided by the requesting surgeon, only that there is a tender 1st dorsal compartment. CMC grind test or Finkelstein's has not been commented on, as well as other examination findings. There is insufficient evidence that MRI is indicated for evaluation of DeQuervain's tenosynovitis. Finally, UR dated 8/11/14 appears to have previously certified MRI bilateral hand/wrist. From ODG, Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. Thus, MRI of the bilateral wrists should not be considered medically necessary. From ODG, Forearm, Wrist and Hand, Radiography: Recommended as indicated below. For most patients with known or suspected trauma of the hand, wrist, or both, the conventional radiographic survey provides adequate diagnostic information and guidance to the surgeon. However, in one large study, wrist fractures, especially those of the distal radius and scaphoid, accounted for more delayed diagnoses than any other traumatized region in patients with initial normal emergency room radiographs. Thus, when initial radiographs are equivocal, or in the presence of certain clinical or biographic findings, further imaging is appropriate. This may be as simple as an expanded series of special views or fluoroscopic spot films; or may include tomography, arthrography, bone scintigraphy, computed tomography (CT), or magnetic resonance (MR) imaging. (ACR (American College of Radiology), 2001) (Dalinka, 2000) For inflammatory arthritis, high-resolution in-office MRI with an average followup of 8 months detects changes in bony disease better than radiography, which is insensitive for detecting changes in bone erosions for this patient population in this time frame. (Chen, 2006) Standard x-rays are the first step in sports injuries. Although arthrography is still the reference for the diagnosis of intrinsic ligament and cartilaginous lesions, MRI can sometimes be sufficient. Ultrasonography is a dynamic process and is accurate in detecting tendon injuries. See also MRI, Ultrasound and X-rays. See also ACR Appropriateness Criteria. Specific indication: - Chronic wrist pain, first study obtained in patient with chronic wrist pain with or without prior injury, no specific area of pain specified. From ODG, Forearm, Wrist and Hand, MRI: Recommended as indicated below. While criteria for which patients may benefit from the addition of MRI have not been established, in selected cases where there is a high clinical suspicion of a fracture despite

normal radiographs, MRI may prove useful. (ACR, 2001) (Schmitt, 2003) (Valeri, 1999) (Duer, 2007) Magnetic resonance imaging 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. It may be diagnostic in patients with triangular fibrocartilage (TFC) and intraosseous ligament tears, occult fractures, avascular neurosis, and miscellaneous other abnormalities. Many articles dispute the value of imaging in the diagnosis of ligamentous tears, because arthroscopy may be more accurate and treatment can be performed along with the diagnosis. (Dalinka, 2000) (Tehranzadeh, 2006) For inflammatory arthritis, high-resolution in-office MRI with an average followup of 8 months detects changes in bony disease better than radiography, which is insensitive for detecting changes in bone erosions for this patient population in this time frame. (Chen, 2006) See also Radiography. Specific indication: - Chronic wrist pain, plain films normal, suspect soft tissue tumor- Chronic wrist pain, plain film normal or equivocal, suspect Kienbck's disease- Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. (Mays, 2008). The request is therefore not medically necessary.

1 Left De Quervain's release: 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): 271, 272.

Decision rationale: The patient is noted to have chronic wrist pain and examination notes a tender first dorsal compartment. However, there has been insufficient documentation of either splinting or steroid injection as recommended by ACOEM. From page 271, ACOEM Chapter 11: The majority of patients with DeQuervain's syndrome will have resolution of symptoms with conservative treatment. Under unusual circumstances of persistent pain at the wrist and limitation of function, surgery may be an option for treating DeQuervain's tendinitis. From page 272, Table 11-7, the following is recommended: Conservative treatment including splinting and Initial injection into tendon sheath for clearly diagnosed cases of DeQuervain's syndrome, tenosynovitis, or trigger finger. Thus, De Quervain's release should not be considered medically necessary.

Pre-op medical clearance: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.