

<b>Case Number:</b>	CM14-0184395		
<b>Date Assigned:</b>	11/12/2014	<b>Date of Injury:</b>	07/24/2012
<b>Decision Date:</b>	02/03/2015	<b>UR Denial Date:</b>	10/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/05/2014

### 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, has a subspecialty in Pain 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:

The injured worker is a 43 year-old male with an original date of injury on 7/22/2012. The patient was injured when he fell at work and hyperextended his right knee. The patient was status post right ACL repair when he sustained another injury, where he stumbled and the crutches jammed his left armpit and left thumb, leading to a left labrum tear found on MRI of the left shoulder. The industrially related diagnoses are right knee ACL tear status post reconstruction, left shoulder superior labrum and posterior labrum tear with paralabral cyst and spinal glenoid notch, lumbar spine spondylolisthesis at L4-L5, and status post left shoulder superior labrum repair. The disputed issue is an MRI of the left hand. A utilization review dated 10/22/2014 has non-certified this request. The stated rationale for denial was due to lack of information supporting the need for this study.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI of The Left Hand:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 269.

**Decision rationale:** Section Forearm, Wrist, and Hand Complaints of the California Code of Regulations, Title 8, page 5 states the following: "The Administrative Director adopts and incorporates by reference the Forearm, Wrist, and Hand Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11) into the MTUS from the ACOEM Practice Guidelines." ACOEM Chapter 11 on pages 268-269 state the following regarding wrist/hand imaging studies: "For most patients presenting with true hand and wrist problems, special studies are not needed until after a four- to six-week period of conservative care and observation. Most patients improve quickly, provided red flag conditions are ruled out. Exceptions include the following: - In cases of wrist injury, with snuff box (radial-dorsal wrist) tenderness, but minimal other findings, a scaphoid fracture may be present. Initial radiographic films may be obtained but may be negative in the presence of scaphoid fracture. 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. - An acute injury to the metacarpophalangeal joint of the thumb, accompanied by tenderness on the ulnar side of the joint and laxity when that side of the joint is stressed (compared to the other side), may indicate a gamekeeper thumb or rupture of the ligament at that location. Radiographic films may show a fracture; stress views, if obtainable, may show laxity. The diagnosis may necessitate surgical repair of the ligament; therefore, a surgical referral is warranted. - In cases of peripheral nerve impingement, if no improvement or worsening has occurred within four to six weeks, electrical studies may be indicated. The primary treating physician may refer for a local lidocaine injection with or without corticosteroids. - Recurrence of a symptomatic ganglion that has been previously aspirated or a trigger finger that has been previously treated with local injections (see Table 11-4) is usually an indication for re-aspiration or referral, based on the treating physician's judgment. - A number of patients with hand and wrist complaints will have associated disease such as diabetes, hypothyroidism, Vitamin B complex deficiency and arthritis. When history indicates, testing for these or other comorbid conditions is recommended. - If symptoms have not resolved in four to six weeks and the patient has joint effusion, serologic studies for Lyme disease and autoimmune diseases may be indicated. Imaging studies to clarify the diagnosis may be warranted if the medical history and physical examination suggest specific disorders. Table 11-6 provides a general comparison of the abilities of different imaging techniques to identify physiologic insult and define anatomic defects." Table 11-6 on page 269 indicates that hand/wrist MRI is recommended for the diagnosis of carpal tunnel syndrome and infection, but not for ligament/tendon strain, tendinitis/tenosynovitis, DeQuervain's tendonitis, trigger finger, and ganglion. Further guidelines are described by the Official Disability Guidelines, which state the following regarding hand/wrist 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. Indications for imaging -- Magnetic resonance imaging (MRI):- Acute hand or wrist trauma, suspect acute distal radius fracture, radiographs normal, next procedure if immediate confirmation or exclusion of fracture is required- Acute hand or wrist trauma, suspect acute scaphoid fracture, radiographs normal, next procedure if immediate confirmation or exclusion of fracture is required- Acute hand or wrist trauma, suspect gamekeeper injury (thumb MCP ulnar collateral ligament injury)- Chronic wrist pain, plain films normal, suspect soft tissue tumor- Chronic wrist pain, plain film normal or equivocal, suspect Kienbock'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)"A progress note dating on 7/15/2014 documented subject finding of left thumb injury status post fall and the crutch jamming into his left shoulder and left thumb. Another progress note dating 9/10/2014 noted left hand tenderness to palpation at the volar aspect of the wrist at the radiocarpal joint. The MRI of the left hand was ordered on the same visit sitting to rule out TFCC tear. Both subjective and objective findings documented support a need for an MRI of left hand. The patient in a subsequent progress note on 10/2/14 is noted to have continued wrist pain the same location. At this juncture, the patient has had at least 3 months of continued pain in this region. Although an x-ray of the wrist is instructive (and is would be advisable according to this author), the main suspicion is for a soft tissue injury to the fibrocartilage complex which would be best revealed through MRI. Given the traumatic nature of this wrist injury and persistence of symptoms, this request is medically necessary.