MAXIMUS Federal Services

| Case Number: | CM15-0031324 | | |
|---|---|---|---|
| Date Assigned: | 02/24/2015 | Date of Injury: | 11/26/2013 |
| Decision Date: | 04/14/2015 | UR Denial Date: | 01/26/2015 |
| Priority: | Standard | Application Received: | 02/19/2015 |

## 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: District of Columbia, Virginia
Certification(s)/Specialty: Internal Medicine

## 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 47 year old male with an industrial injury dated November 26, 2013. The injured worker diagnoses include bilateral carpal tunnel syndrome, cervical sprain/strain, myofascial pain and thoracic sprain/strain. He has been treated with diagnostic studies, radiographic imaging, prescribed medications and periodic follow up visits. According to the progress note dated 1/21/2015, the injured worker presented for follow visit for complaints of bilateral wrist/hand and upper and mid back pain. The physician noted that the injured worker continues to have intermittent cramping muscles on top of left hand or thumb towards the rest of the body with activity only, but less than before. The treating physician requested more recent MRI of bilateral wrists due to persistent pain and numbness/tingling, especially with activity. The treating physician prescribed services for MRI right wrist without contrast and MRI of left wrist without contrast. Utilization Review determination on January 26, 2015 denied the request for MRI right wrist without contrast and MRI of left wrist without contrast, citing MTUS Guidelines.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Magnetic Resonance Imaging (MRI) Right Wrist without Contrast:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment Index, 13th Edition (Web), 2015, Forearm, Wrist & Hand, MRI.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 258-260.

**Decision rationale:** Per ACOEM: Several traditional findings of carpal tunnel syndrome (CTS) have limited specific diagnostic value. The various tests for CTS show a broad range of sensitivity, depending on the patient population. Clinicians should depend on more than one test. The most sensitive screening methods seem to be an abnormal Katz hand diagram, abnormal sensibility by Semmes-Weinstein testing, and night discomfort. Hypalgesia in the median nerve distribution and thumb abduction strength testing also have been found to be helpful in establishing the diagnosis of CTS. The flick sign is another diagnostic tool. (The sign is positive when a patient reports shaking his or her hand in an effort to relieve parathesias.) Table 11-3 lists various tests for CTS along with estimated sensitivity and specificity based on meta analysis of existing studies. Trigger finger nodules may be palpable both actively and passively. There may be only palmar tenderness over proximal interphalangeal joints. The presence of a ganglion is easily determined, but the severity of any symptoms is the basis for a decision to aspirate or, in persistent cases, to excise the cyst. B. Neurovascular Screening. The neurologic and vascular status of the hand, wrist, forearm, and elbow, including peripheral pulses, and the motor, reflex, and sensory status of the forearm, hand, and wrist as well as the more proximal surrounding structures, can be assessed. Examining the neck and cervical nerve root function is also in order because C6-radiculopathy can affect the wrist extensors and T1-radiculopathy can present as dysfunction of the intrinsic muscles of the hand (see Table8-3). C. Assessing Red Flags; The forearm, wrist, and hand area may present with signs of serious infection or tumor (rarely metastatic) or manifest symptoms and signs of serious systemic disease (e.g., inflammatory arthritis, vascular disease), or neurologic conditions. Significant trauma requires evaluation for fracture or crush injury, while a history of deformity consistent with dislocation and spontaneous reduction requires surgical (preferably hand surgery) consultation. Diagnostic Criteria; If there are no red flags present to indicate serious conditions, the clinician can then determine which common musculoskeletal disorder is present. The criteria presented in Table 11-2 follow the clinical thought process, from the mechanism of illness or injury to unique symptoms and signs of a particular disorder and, finally, to test results if any tests are needed to guide treatment at this stage. From the clinical data provided, there is no indication for MRI as part of the diagnosis. This testing would not be indicated.

**Magnetic Resonance Imaging (MRI) Left Wrist without Contrast:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment Index, 13th Edition (Web), 2015, Forearm, Wrist & Hand-MRI.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 258-260.

**Decision rationale:** Per ACOEM: Several traditional findings of carpal tunnel syndrome (CTS) have limited specific diagnostic value. The various tests for CTS show a broad range of sensitivity, depending on the patient population. Clinicians should depend on more than one test. The most sensitive screening methods seem to be an abnormal Katz hand diagram, abnormal sensibility by Semmes-Weinstein testing, and night discomfort. Hypalgesia in the median nerve distribution and thumb abduction strength testing also have been found to be helpful in establishing the diagnosis of CTS. The flick sign is another diagnostic tool. (The sign is positive when a patient reports shaking his or her hand in an effort to relieve parathesias.) Table 11-3 lists various tests for CTS along with estimated sensitivity and specificity based on meta-analysis of existing studies. Trigger finger nodules may be palpable both actively and passively. There may be only palmar tenderness over proximal interphalangeal joints. The presence of a ganglion is easily determined, but the severity of any symptoms is the basis for a decision to aspirate or, in persistent cases, to excise the cyst. B. Neurovascular Screening. The neurologic and vascular status of the hand, wrist, forearm, and elbow, including peripheral pulses, and the motor, reflex, and sensory status of the forearm, hand, and wrist as well as the more proximal surrounding structures, can be assessed. Examining the neck and cervical nerve root function is also in order because C6-radiculopathy can affect the wrist extensors and T1-radiculopathy can present as dysfunction of the intrinsic muscles of the hand (see Table8-3). C. Assessing Red Flags; The forearm, wrist, and hand area may present with signs of serious infection or tumor (rarely metastatic) or manifest symptoms and signs of serious systemic disease (e.g., inflammatory arthritis, vascular disease), or neurologic conditions. Significant trauma requires evaluation for fracture or crush injury, while a history of deformity consistent with dislocation and spontaneous reduction requires surgical (preferably hand surgery) consultation. Diagnostic Criteria; If there are no red flags present to indicate serious conditions, the clinician can then determine which common musculoskeletal disorder is present. The criteria presented in Table 11-2 follow the clinical thought process, from the mechanism of illness or injury to unique symptoms and signs of a particular disorder and, finally, to test results if any tests are needed to guide treatment at this stage. From the clinical data provided, there is no indication for MRI as part of the diagnosis. This testing would not be indicated.