

Case Number:	CM15-0047403		
Date Assigned:	03/19/2015	Date of Injury:	05/25/2014
Decision Date:	04/24/2015	UR Denial Date:	03/11/2015
Priority:	Standard	Application Received:	03/12/2015

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: Illinois, California, Texas
 Certification(s)/Specialty: Orthopedic Surgery

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 51-year-old female who sustained an industrial injury on 5/25/14. Injury occurred while she was packing trays and a tray struck her forcefully in the left wrist and hyperextended the wrist. Records documented conservative treatment including anti-inflammatory medications, Neurontin, stellate ganglion blocks, intraarticular corticosteroid injections, 6 visits of physical therapy, activity modification, and home exercise. The 7/31/14 left wrist MRI impression documented evidence of dorsal radial carpal synovitis/sprain. There was a small amount of extruded fluid along dorsum of the wrist adjacent to the distal radius. There was a volar distal radial ganglion cyst with extruded joint fluid/ganglion cyst along the inferior pisotriquetral recess. There was attenuation of the triangular fibrocartilage complex along the dorsal ulnar attachment compatible with degeneration and partial disruption, with no evidence of a transmural tear. The 7/31/14 upper extremity electrodiagnostic study was reported normal. The 2/12/15 orthopedic follow-up report cited left wrist pain and swelling. She had difficulty putting any pressure on her wrist in a dorsiflexed position and complained of a popping sensation in the wrist. MRI showed a potential intra-articular ganglion and synovitis. Right wrist exam documented dorsiflexion 10 degrees, plantar flexion 15 degrees, and ulnar and medial deviation 15 degrees. There was palpable swelling over the dorsum of the wrist, and grip strength 12 pounds left, 40 pounds right. The diagnosis was left wrist synovitis with questionable intraarticular ganglion cyst. The injured worker had prior intraarticular cortisone injections performed with a week of improvement, followed by a return of swelling. Conservative treatment had failed and authorization was requested for left wrist arthroscopy with potential

resection of synovitis and intraarticular ganglion. The 3/2/15 treating physician report cited a severe flare-up of burning left hand pain shooting in the left upper extremity. She had previous 60% relief with left-sided stellate ganglion block and authorization was requested for a repeat block. The treatment request included a left wrist arthroscopy with potential resection of synovitis and intraarticular ganglion as recommended by the orthopedic surgeon. The 3/11/15 utilization review non-certified the request for left wrist arthroscopy with potential resection of synovitis and intraarticular ganglion as there was no documentation of conservative treatment with physical therapy, that other diagnoses had been ruled-out, or that diagnostic criteria for complex regional pain syndrome had been met. The 3/14/15 treating physician report appeal letter indicated that the injured worker had enough conservative treatment, including physical therapy, medication management and stellate ganglion blocks. The patient had 60% relief with previous stellate ganglion block that confirms the diagnosis of complex regional pain syndrome. The orthopedic surgeon had recommended resection of synovitis and intraarticular ganglion based on MRI findings of dorsal radial carpal synovitis with fluid on the dorsum of the left wrist.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left wrist arthroscopy with potential resection of synovitis and intraarticular ganglion:
Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation The American Medical Association Guide to the Evaluation of Disease and Injury Causation, Official Disability Guidelines-Treatment for Workers' Compensation (ODG-TWC): Work Loss Data Institute, LLC; Corpus Christi, TX; www.odg-twc.com; Section: Forearm, Wrist & Hand (Acute & Chronic) (updated 11/13/2014).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 271. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist & Hand: Surgery for ganglion cysts and Other Medical Treatment Guidelines Adolfsson L. Arthroscopic synovectomy of the wrist. Hand Clin. 2011 Aug;27(3):395-9. doi: 10.1016/j.hcl.2011.06.001. Epub 2011 Jul 13.

Decision rationale: The California MTUS ACOEM guidelines state that only symptomatic wrist ganglia merit excision, if aspiration fails. The Official Disability Guidelines recommend surgery for ganglion cysts as an option when a cause of pain, interference with activity, nerve compression and/or ulceration of the mucous cysts. Peer-reviewed literature supports arthroscopic synovectomy as safe and reliable, with mild postoperative morbidity. The rationale of a surgical synovectomy is to excise inflamed synovium and thereby, remove as much effusion and inflammatory substrate as possible. Guideline criteria have been met. This patient presents with persistent left dorsal left hand pain and swelling. Clinical exam findings are consistent with imaging evidence of dorsal radial carpal synovitis and ganglion cyst. Conservative treatment, including multiple injections, have been tried and failed to provide sustained benefit. Therefore, this request is medically necessary.