

<b>Case Number:</b>	CM15-0095638		
<b>Date Assigned:</b>	05/22/2015	<b>Date of Injury:</b>	04/26/2011
<b>Decision Date:</b>	06/25/2015	<b>UR Denial Date:</b>	04/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/18/2015

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 56 year old female who sustained a work related injury April 26, 2011. According to a panel qualified medical evaluation, dated September 9, 2014, she was injured while performing her daily activities, doing repetitive movements with both hands. She initially developed numbness in both hands with pain in the wrists. She underwent a left carpal tunnel release in January 2012 and right carpal tunnel release in April, 2012. She continued to have numbness in both hands but more on the left than the right. Past history included hypertension and arthritis. An MRI of the left wrist with arthrogram dated July 17, 2013, revealed a 7.5mm region of avascular necrosis along the ulnar articular surface of the lunate; subchondral cyst formation present within the lunate and scaphoid. An MRI of the right wrist with arthrogram dated July 17, 2013, revealed subchondral cyst formation within the lunate; small ulnocarpal joint effusion. Diagnoses are ulnar nerve entrapment, left elbow; bilateral carpal tunnel syndrome; Kienbock's disease. At issue, is the retrospective request for authorization of an MRI for the left wrist with arthrogram and an MRI of the right wrist with arthrogram; date of service 7/17/2013.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective request for MRI of the left wrist with flex-ext with arthrogram, provided on date of service: 07/17/13: Overturned**

**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 (ODG), Forearm, Wrist, and Hand, MRI and on the Non-MTUS Wrist MRI Arthrogram v Wrist Arthroscopy: What are we Finding? Aatif Mahmood, James Fountain, Neveen Vasireddy, and Mohammed Waseem.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 269. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, and Hand and Carpal Tunnel Syndrome Chapters.

**Decision rationale:** Regarding the request for MRI of right wrist with contrast, 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. Within the documentation available for review, there is documentation of continued pain beyond 4-6 weeks. The patient sustained original injury in April 2011. The MRI was performed in July 2013, which is over two years later. In the interim, the worker underwent a carpal tunnel release, yet the patient continued with numbness and pain. The clinical picture is further complicated by the presence of non-industrial Kienbock's disease affecting the left side. Given this, an MRI to clarify the extent of Kienbock's disease as well as to evaluate for other pathology entities would be indicated given the time frame of chronic pain. This MRI is medically necessary.

**Retrospective request for MRI of the right wrist with flex-ext with arthrogram, provided on date of service: 07/17/13: Overturned**

**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 (ODG), Forearm, Wrist, and Hand, MRI and on the Non-MTUS Wrist MRI Arthrogram v Wrist Arthroscopy: What are we Finding? Aatif Mahmood, James Fountain, Neveen Vasireddy, and Mohammed Waseem.

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