

MAXIMUS FEDERAL SERVICES, INC.

Independent Medical Review
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Notice of Independent Medical Review Determination

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

- 1) MAXIMUS Federal Services, Inc. has determined the MR Arthrogram of the right wrist requested **is medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 3/29/2013 disputing the Utilization Review Denial dated 3/22/2013. A Notice of Assignment and Request for Information was provided to the above parties on 4/25/2013. A decision has been made for each of the treatment and/or services that were in dispute:

- 1) MAXIMUS Federal Services, Inc. has determined the MR Arthrogram requested **is medically necessary and appropriate.**

Medical Qualifications of the Professional Reviewer:

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Occupational 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 professional 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 treatments and/or services at issue.

Case Summary:

Disclaimer: The following case summary was taken directly from the utilization review denial/modification dated March 22, 2013.

“The patient is a 58 year-old female with a date of industrial injury of 02/02/13. According to an orthopedic evaluation on 02/04/13, there was mention that the patient had a fall on an outstretched right hand and that x-rays were obtained and a splint was applied, and there was a questionable wrist fracture. Also, per 02/04/13 note, there was mention of a metal splint that was removed. Fingers had moderate swelling and wrist hand mild dorsal swelling. There was stiffness associated with finger movement. Palpation of the wrist showed minimal discomfort with pressure over the volar lip of the distal radius, and otherwise, physical exam was unremarkable. Also, per 02/04/13 note, there was mention of x-rays of the right wrist that showed some cystic changes in the scaphoid and lunate that were old and that there were no signs of acute injuries or fractures and there was evidence of diffuse degenerative arthritis. The patient was diagnosed as having a right wrist sprain/contusion. The treatment plan at that point was for the patient to be treated with a joint immobilization and a short arm volar plaster splint was applied. According to a clinic note on 02/11/13, there was mention of the patient’s hand feeling better, right wrist swelling was decreasing. There was some moderate swelling on the dorsum of the wrist. Motion was limited. There no sensory deficits. Fingers had good perfusion and x-rays of the right wrist showed cystic changes in the lunate and scaphoid and some arthritic changes, but no evidence of any acute fracture. The patient was listed again, as having right wrist sprain/contusion and was given a removable brace, short course of steroid medication, and topical pain and anti-inflammatory medication; also he was to start therapy for modalities, range of motion, and eventual progressive strengthening, and to recheck in two weeks. In a clinic follow-up note on 02/25/13, there was mention that the patient had no pain unless there was pressure put on the wrist and that the area of pain was pressure put on the area of pain was at the radial scapholunate area and there was still light thickening of the soft tissue surrounding the wrist. The other areas of the wrist were pain-free and motion of the wrist was limited. Right wrist range of motion with volar flexion was 35 degrees,

dorsiflexion 50 degrees, grip strength was decreased on the right and the listed diagnosis included right wrist sprain/contusion and rule out scapulolunate ligament tear. The treatment plan was still waiting for authorization for physical therapy and to obtain an MR arthrogram of the wrist to rule out any ligamentous injury and to recheck in 3 weeks, and for modified duties with restrictions.”

Documents Reviewed for Determination:

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application for Independent Medical Review received 3/29/2013
- Utilization Review Determination provided by [REDACTED] dated 3/22/2013
- Medical Records provided by [REDACTED] dated 2/03/2013
- Medical Records provided by [REDACTED] dated 2/04/through 3/18/2013
- American College of Occupational and Environmental Medicine (ACOEM) guidelines, 2nd Edition, 2004, Hand, Wrist, and Forearm, pages 271-273
- Official Disability Guidelines, 2009, Hand Section

1) Regarding the request for an MR Arthrogram of the right wrist:

Section of the Medical Treatment Utilization Schedule Relied Upon by the Professional Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the American College of Occupational and Environmental Medicine (ACOEM) guidelines, 2nd Edition, 2004, Hand, Wrist, & Forearm, pages 271-273, of the Medical Treatment Utilization Schedule (MTUS), and the Official Disability Guidelines, 2009, Hand Section, of the Medical Treatment Utilization Schedule (MTUS). The provider did not dispute the guidelines used by the Claims Administrator. The Professional Reviewer found that the guidelines used by the Claims Administrator were not appropriate for the employee’s clinical circumstance. The employee’s clinical condition was described as right wrist sprain/contusion; however, based on the findings of submitted and reviewed medical records, the employee’s clinical condition is more appropriately described as possible scapholunate ligament tear. The American College of Occupational and Environmental Medicine (ACOEM) guidelines, 2nd Edition, 2004, Hand, Wrist, & Forearm, pages 271-273, of the Medical Treatment Utilization Schedule (MTUS), and the Official Disability Guidelines, 2009, Hand Section, of the Medical Treatment Utilization Schedule (MTUS), are not applicable to the employee’s condition; therefore the Professional Reviewer used the American College of Radiology Guidelines, ACR Appropriateness Criteria, Clinical Condition: Chronic Wrist Pain.

Rationale for the Decision:

The employee was treated for a right wrist injury which resulted from falling on outstretched hands on 2/02/2013. The patient was treated with conservative care, including analgesic medications, topical analgesics, and wrist bracing without positive effect. The date of request for an MR Arthrogram was March 14, 2013, approximately six weeks after the date of injury of February 2, 2013. At that point the employee continued to have significant symptoms of wrist pain and

swelling. According to the reviewed submitted medical records, the treating provider suspected a possible scapholunate tear as a differential diagnosis and recommended an MR Arthrogram of the right wrist. The ACOEM guidelines suggest that typical special studies are not needed until after four to six weeks period of conservative care and observation. The Medical Professional Reviewer felt that the American College of Radiology (ACR) Criteria on chronic wrist pain more specifically addresses the topic of MR Arthrography for the diagnosis of a suspected scapholunate ligament tear. The ACR Criteria states that “for scapholunate ligament tears, direct MR arthrography is superior to both MRI and conventional arthrography, especially for subtle injuries. MR arthrography may permit exact localization of tears and inform about adjacent structures, including cartilage and ligaments. Direct MR arthrography is recommended for clinically relevant suspected tears of the peripheral ulnar attachments of the triangular fibro cartilage complex (TFCC) because of its improved accuracy compared to conventional MRI.” Based on review of the submitted medical records and the ACR Criteria on chronic wrist pain support, the Medical Professional Reviewer has determined that the requested MR Arthrogram **is medically necessary and appropriate.**

Effect of the Decision:

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely;

Richard C. Weiss, MD, MPH, MMM, PMP
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

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Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.