



**CLAIMS EVAL**

*Utilization Review and  
Peer Review Services*

Notice of Independent Review Decision-WC

**CLAIMS EVAL REVIEWER REPORT - WC**

**DATE OF REVIEW: 9-17-09**

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

CT scan of the right wrist

**A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION**

American Board of Orthopaedic Surgery-Board Certified

**REVIEW OUTCOME**

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
- Overturned (Disagree)
- Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

### **INFORMATION PROVIDED TO THE IRO FOR REVIEW**

- , MD., office visits from 5-28-09 through 7-27-09.
- 7-20-09 MRI of the right wrist.
- 8-3-09 , MD., conference note.
- 8-5-09 , MD., Utilization Review.
- 8-5-09 , MD., letter.
- 8-13-09 , DO., Utilization Review.

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

Medical records reflect the claimant was injured on xx/xx/xx. The claimant suffered a severe laceration to wrist with injuries to right median and ulnar nerves and tendons. The patient later developed forearm severe pain with diagnosis of CRPS and right carpal tunnel syndrome. He continues with right arm and wrist pain. He also complains of pins and needles in the right wrist. He is on Topamax and Motrin. The claimant is reported to be being followed for right upper extremity pain secondary to distal forearm injury to medial and ulnar nerves and several tendons. It is reported the patient developed complex regional pain syndrome and carpal tunnel syndrome, which is chronic.

Followup visit with Dr. on 5-28-09 notes the claimant saw Dr. who felt the claimant needed an EMG of the right upper extremity and an MRI to rule out neuroma and other causes.

MRI of the right wrist dated 7-20-09 showed a focal susceptibility signal loss within the volar soft tissues of the wrist at the level of the radiocarpal joint with potential mass effect upon the flexor tendons within the proximal most position of the carpal tunnel. The evaluator suggested a CT scan to assess the overall size of the paramagnetic fragment and its exact relationship to the tendons. There is mild tendinitis within the extensor carpal ulnaris tendon. There are mild degenerative changes of the radiocarpal joint.

On 7-27-09, , MD., noted the claimant has been followed for a right upper extremity pain secondary to a distal forearm injury to the median and ulnar nerve and several tendons on xx/xx/xx. He has developed CRPS and carpal tunnel syndrome, which are

chronic. The claimant presents with complaints of right hand and wrist pain. On exam, the claimant has hyperpathia. There is tenderness to palpation in the dorsum and volar aspects of the right wrist. The evaluator reported sensations of "shocking" when he palpated his wrist. There is opponens pollicis weakness rated at 3/5. He has extension weakness of the thumb, second and third fingers rated as 4/5. Upper DTR are 1 and symmetric bilaterally. The evaluator requested a CT scan of the right wrist to determine possible etiologies for his right wrist symptoms. The evaluator also ordered an EMG of the upper extremity to further evaluate the right wrist and numbness. The claimant will continue on Ibuprofen and Topamax.

On 8-3-09, , MD., provided a conference note. The evaluator reported he had a telephone conversation with Dr. . The evaluator reported that at the 7-27-09 visit, he ordered a CT scan of the right wrist as well as an EMG of the upper extremity. The evaluator explained that the radiologist that performed the MRI of the right wrist recommended a CT scan. The evaluator noted that the claimant had an independent medical evaluation with Dr. on 12-29-08 and he also felt the claimant needed an EMG of the right upper extremity.

8-5-09 , MD., Utilization Review - it was the evaluator's opinion that the claimant has chronic right wrist pain with pins and needles radiating into the thumb. Although the radiologist has recommended CT scan of the wrist for further assessment of the tendons, it is not tantamount to a medical necessity. James, the PA stated that he was requesting the CT scan of the wrist as per the recommendation of the radiologist. He was unable to cite a valid medical reason for the request. The symptoms seem to be due to questionable CTS. ODG recommends CT scan to detect bony abnormalities rather than soft tissue problems.

8-5-09 , MD., letter - the evaluator noted that the claimant is currently under his care for an on-the-job injury on xx/xx/xx. He injured his right wrist. He underwent an MRI Scan of the right wrist on 7-22-09. The radiologist recommended a CT scan of the right wrist and stated in his report, "A CT Scan would be of benefit to assess the overall size of this paramagnetic fragment in it's exact relationship to the tendons." A CT Scan of the right wrist was ordered but denied by the insurance carrier. We would like to appeal this denial as the CT scan of the right wrist is clearly indicated to evaluate the changes noted by the radiologist on the MRI scan.

8-13-09 , DO., Utilization Review - it was the evaluator's opinion that the request for CT scan of the right wrist is not supported by the submitted clinical information. Limited clinical records were presented on the patient. It is noted he has undergone MRI of the right wrist on 07-20-09. This study reported a focal susceptibility signal loss within volar soft tissues of wrist at the level of radiocarpal joint with potential mass effect on the flexor tendons within proximal most portion of the carpal tunnel. MRI is certainly more specific in this case and is unclear as to the diagnostic yield that a CT would provide. Further clinical information and insight may establish medical necessity of this request.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.**

Based on the medical records provided, there is no indication for a CT scan at this juncture. It is not clear why a CT scan is being requested and what information is expected to yield. Therefore, non-certification is provided for the requested procedure.

**ODG-TWC, last update 8-24-09 Occupational Disorders of the wrist, hand and forearm – CT scan:** Recommended for indications below. In distal radius fractures where there is a high likelihood of intra-articular incongruence, such as fractures in young adults, which frequently result from high-energy impact loading, selective or even routine use of CT to supplement the standard radiographic examination is warranted. (ACR, 2001) (Dalinka, 2000)

Indications for imaging -- Computed tomography (CT):

- Acute hand or wrist trauma, scaphoid fracture on films, concern for displacement or age of fracture
- Acute hand or wrist trauma, comminuted distal radius fracture, suspect incongruity of joint
- Acute hand or wrist trauma, suspect distal radioulnar joint subluxation
- Acute hand or wrist trauma, suspect hook of the hamate fracture, initial radiographs normal or equivocal
- Acute hand or wrist trauma, suspect metacarpal fracture or dislocation, if strong clinical concern exists following negative or equivocal plain film
- Chronic wrist pain, pain for more than 3 weeks, suspect occult fracture possibly hamate, plain films nondiagnostic

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA

- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)