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**Notice of Independent Medical Review Decision**

**Reviewer's Report**

**DATE OF REVIEW:** X

**IRO CASE #:** X

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

X

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

X

**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)

I have determined that X is not medically necessary for treatment of this member's condition.

**INFORMATION PROVIDED TO THE IRO FOR REVIEW**

X

**PATIENT CLINICAL HISTORY [SUMMARY]:**

X. The Carrier denied this request on the basis that these services are not medically necessary for treatment of the member's condition.

On X, the member's treating physician wrote a letter in support of this request. It indicated that on X the member sustained a work related injury which occurred X. It noted that initial x-rays were X. It indicated that the member completed a X. It noted that magnetic resonance imaging (MRI) was done with findings of X. It indicated that it showed a X. It noted that there was a X. It indicated that there was also X. It noted that it also revealed an X. It indicated that the member saw another doctor on three different visits where X. It noted the films and MRI pointed to a X. It indicated that the member stated that the member's diagnosis point to X. It indicated that a X. It noted that the member has been re-evaluated on X with recurrence of symptoms.

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

The Maximus physician consultant noted that this is a X who sustained an industrial injury on X and is seeking authorization for X for the treatment of X. The Carrier denied this request indicating that it was not medically necessary for the member's medical condition.

The Maximus physician consultant indicated that prior diagnostic testing included MRI of the right wrist dated X had impressions of scapholunate ligament high-grade sprain/partial thickness tear with widening of the scapholunate interval; TFCC articular disc proper central full thickness tear with fraying; triangular ligament intermediate grade sprain along the foveal and ulnar styloid attachments; moderate distal radial ulnar joint effusion; extensor carpi ulnaris tendon longitudinal split tear with tenosynovitis of the ulnocarpal segment. MRI of the right wrist dated X had impressions of a full-thickness tear of the volar and membranous aspects of the scapholunate ligament and further evaluation with MRI wrist arthrogram may be beneficial; moderate degenerative changes with equivocal pinhole full-thickness tear of the radial aspects of the triangular fibrocartilage disc; numerous punctate focal bony lesions measuring approximately 1millimeter (mm) throughout the wrist consistent with bony erosions of inflammatory arthropathy until proven otherwise; minimal/mild arthritic changes of the radiocarpal joints now with minimal/mild tricompartmental stiffness and/or synovitis. Previous treatment has included X.

The Maximus physician consultant noted that a progress report dated X has the injured worker with pain, tingling, and swelling of the right wrist/thumb that is moderate and constant. The pain can go up to a X out of X. The pain starts on the wrist and goes up to the thumb or the forearm. The member pointed to the volar radial wrist and traces longitudinally. The examination (exam) revealed right supination is X, pronation is X, wrist flexion is X, and wrist extension X. There is tenderness at the FCR (flexor carpi radialis). X-rays are noted to show X. The member was provided with an X.

The Maximus physician consultant indicated that a progress report dated X had the injured worker with mild, constant pain, tingling, and swelling in the right wrist and thumb. The member continued to localize to FCR highly specific. The member noted about X percent (%) response with the X for the first week and has then worsened but has not returned to the original level remaining about X compared to prior at this time. The exam revealed right supination is X, pronation is X, wrist flexion is X, and wrist extension X. There is tenderness at the FCR with high-grade sensitivity. The treatment plan included X.

The Maximus physician consultant noted that a progress report dated X had the injured worker with constant, moderate pain, stiffness, and swelling in X right wrist. The member noted some improvement with X. The right wrist pain, stiffness, and swelling was rated at X out of X. The member was working in a restricted capacity. The exam of the right wrist revealed extension X and flexion X. There was X. There was X. There was point tenderness of the right thumb at the CMC (carpometacarpal) joint. Right wrist with PMT at the first dorsal compartment and TMC. There was global stiffness but no apparent instability or other point of significant pain. The neurological exam was intact. The treatment plan included X.

The Maximus physician consultant indicated that a provider letter dated X cited that the member sustained a work injury on X to the right wrist/hand hyper-pronation motion. X-rays were obtained and noted to be X. The member X. The imaging study showed a X. The member underwent X. This study pointed to a SLAC II static with scapholunate ligament (S-L) deficiency but this does not correlate with history and clinical findings. The member presented to this office on X with symptoms of severe activity-related pain, stiffness, and swelling in X right hand/wrist. The exam showed right wrist with PMT at the first dorsal compartment and TMC joint. The member has global stiffness but there was no apparent instability or other point of significant pain. The epicenter of the member's problem on that evaluation was at the TMC joint and first dorsal compartment. A X resolved X symptoms temporarily. The member was re-evaluated on X with a recurrence of symptoms. X was recommended.

The Maximus physician consultant noted that as per Official Disability Guidelines (ODG), "Not recommended for advanced arthritic conditions of the finger proximal interphalangeal joint or thumb carpometacarpal joint. Although not recommended, if performed only for non-working, low-strength demand individuals (for example [e.g.], rheumatoid arthritis), the following criteria should be met: Symptomatic arthritis of the proximal interphalangeal joint with preservation of the collateral ligaments; Sufficient bone support; Intact or reconstructable extensor and flexor tendons. Contraindications include instability (e.g., rheumatoid arthritis, traumatic ligament loss), non-reconstructable extensor tendons, infection, and poor patient compliance" (ODG).

The Maximus physician consultant noted that however, detailed documentation was not evident regarding significant, diagnostic imaging corroboration of pathology in the right CMC joint. Additionally, the member was noted to have had an injection at the first dorsal compartment, but no injection specifically for the CMC joint. There was no compelling rationale presented or extenuating circumstances noted to support the medical necessity of this request as an exception to guidelines.

Therefore, the requested authorization and coverage for X is not medically necessary for the treatment of the member's condition.

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**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**
- AHRQ-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:**  
Forearm, Wrist, and Hand Conditions Arthroplasty, Finger and/or Thumb (Joint Replacement) for Forearm, Wrist, and Hand Conditions
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- TMF SCREENING CRITERIA MANUAL**
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE**
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**