

Case Number:	CM13-0032778		
Date Assigned:	12/06/2013	Date of Injury:	06/01/2010
Decision Date:	12/24/2014	UR Denial Date:	09/24/2013
Priority:	Standard	Application Received:	10/08/2013

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. The expert reviewer is Board Certified in Family Medicine and is licensed to practice in New Jersey. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 worker is a 51 year old female who was injured on 6/1/2010. She was diagnosed with lesion of ulnar nerve, pain in upper arm joint, pain in hand joint, shoulder pain, wrist sprain, and carpal tunnel syndrome. MRI of the left wrist from 5/9/2011 was essentially normal except for small well demarcated cysts palmar distal triquetrum. She was treated with physical therapy, which reportedly didn't provided any response for the first year, continuing to experience numbness and pain in her hands and wrists. She continued working full time, but with light duty. EMG/NCS testing of the upper extremities was completed on 9/28/2012 demonstrating likely median neuropathy bilaterally and no evidence of ulnar or radial neuropathy at the wrist or elbow. Later, on 8/21/2013, the worker was seen by a hand surgeon who reviewed her history, which included ongoing and unchanged intermittent throbbing pain most of the day in the left thumb, dorsal hand, wrist, forearm, upper arm and constant left thumb numbness. She also reported neck pain. She reported taking lidocaine patches and NSAIDs as well as nortriptylline. Physical examination revealed decreased sensation of left thumb, normal hand strength, negative carpal provocative testing (negative Phalen's, negative Tinel's, negative Durkan carpal tunnel compression testing), negative Guyon's canal provocative testing, tenderness of the left mid radial forearm and thumb CMC joint and of the right medial epicondyle and thumb CMC joint, negative Finkelstein's test, negative testing for carpal instability. The surgeon suspected "possible minimal carpal tunnel syndrome" and "left upper extremity pain, probably nonspecific myalgia" and was recommended repeat nerve testing which the surgeon thought would likely be the same results as the prior testing. The surgeon also offered to trial a steroid injection to the left wrist, and only if she failed this would surgery be considered. Soon afterwards, the worker was seen by her primary treating physician reported the most recent 12 sessions of physical therapy was helpful (no specifics provided in the notes). Physical examination revealed negative carpal

provocative testing, positive Finkelstein's test of the left wrist/hand and decreased sensation of the left medial, lateral, and right distal thumb of the left side. She was then recommended to complete 6 more sessions of physical therapy, continue her topical and oral medications, and complete the surgeon's request for repeat EMG/NCS testing.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy, 6 sessions to Progress to HEP: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99..

Decision rationale: Physical therapy in the form of passive therapy for the hand and arm is recommended by the MTUS Guidelines as an option for chronic neuropathic pain during the early phases of pain treatment and in the form of active therapy for longer durations as long as it is helping to restore function, for which supervision may be used if needed. The MTUS Guidelines allow up to 8-10 supervised physical therapy visits over 4 weeks for neuralgia, neuritis, and radiculitis type pain. The goal of treatment with physical therapy is to transition the patient to an unsupervised active therapy regimen, or home exercise program, as soon as the patient shows the ability to perform these exercises at home. In the case of this worker, she completed multiple sessions of physical therapy, some soon early in her treatment history and at least 12 sessions from her recent treatment leading up to this request. There was no evidence suggesting she required special instruction in order for her to perform her home exercises, and no evidence was found suggesting she was unable to perform them at all. At this point, she should be skilled with home exercises, and a continuation of home exercises is sufficient moving forward to complete her helpful physical therapy, according to the evidence found in the notes provided for review. Therefore, the 6 additional sessions of Physical Therapy are not medically necessary.

EMG of the Bilateral Upper Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

Decision rationale: The MTUS ACOEM Guidelines for neck and arm/wrist complaints suggests that most patients do not require any special studies unless a 3-4 week period (for neck) or 4-6 period (for wrist) of conservative care and observation fails to improve symptoms. When the neurologic examination is less clear or if nerve symptoms worsen, EMG and NCV tests may be considered to help clarify the cause of neck or arm symptoms. In the case of this worker, the

evidence from the hand surgeons note as well as the primary treating physician's note suggested that the EMG and NCS testing would likely show no change from the prior testing, and the surgeon gave the opinion that no surgery would be even considered until she had completed and failed a corticosteroid injection or injections. There is no evidence to suggest the nerve testing would result in any significant change in care or outcome for this worker, therefore the request is medically not necessary.

NCS of the Bilateral Upper Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178..

Decision rationale: The MTUS ACOEM Guidelines for neck and arm/wrist complaints suggests that most patients do not require any special studies unless a 3-4 week period (for neck) or 4-6 period (for wrist) of conservative care and observation fails to improve symptoms. When the neurologic examination is less clear or if nerve symptoms worsen, EMG and NCV tests may be considered to help clarify the cause of neck or arm symptoms. In the case of this worker, the evidence from the hand surgeons note as well as the primary treating physician's note suggested that the EMG and NCS testing would likely show no change from the prior testing, and the surgeon gave the opinion that no surgery would be even considered until she had completed and failed a corticosteroid injection or injections. There is no evidence to suggest the nerve testing would result in any significant change in care or outcome for this worker, therefore the request is medically not necessary.