

Case Number:	CM13-0040227		
Date Assigned:	12/20/2013	Date of Injury:	04/12/2012
Decision Date:	05/02/2014	UR Denial Date:	10/18/2013
Priority:	Standard	Application Received:	10/29/2013

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 Physical Medicine & Rehabilitation, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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 patient is a 32 year old female who has a date of work injury 4/12/12 to her right wrist. Her diagnosis includes right wrist disruption- status post surgery, right scapholunate dissociation- status post surgery, translocated digital nerve in the right wrist as described by the orthopedic surgeon, status post surgery, clinical depression. There is a 10/10/13 supplemental secondary treating physician report which states that the patient remains off work. She notes some worsened pain along the dorsum of her wrist dorsal ulnar wrist. She notes the dorsum of the right little finger and mid dorsal of the hand are numb. There is no numbness on the palmar aspect. She is wearing her brace more and more. Objective findings reveal a right carpal tunnel style brace in position. She has 67 degrees of volar flexion, 75 degrees of dorsiflexion. There is no obvious wrist swelling. There is no distal ulnar asymmetry. There is bloatment of the distal ulna. Initially there was some discomfort but subsequently no discomfort and there is no laxity or tightness difference compared to the unaffected left. Ulnar wrist deviation, pronation, and supination cause no discomfort. There is tenderness in the ulnar snuffbox TFC and some with pressure on the triquetrum. There is no pisotriquetral discomfort. Scaphoid shift test is negative, but there is no discomfort with pressure on the pole of the scaphoid. Grip strength is decreased on the right as compared to the left. Tinel's and carpal's tunnel compression test are negative. There is no radiating numbness or tingling with pressure on the ulnar nerve at the elbow. Percussion along her ulnar and dorsal wrist incisions cause no radiating discomfort or any increased discomfort. An MRI dated October 2, 2013 revealed evidence of radiolunate osteoarthritis and intact TFC. The hand surgeon states that for treatment the patient can use her right hand as needed within limits of discomfort and there is no anatomical problems that can be localized for him treat with injections and certainly not further surgery. There does not seem to

be any instability. Further pain specialist management is recommended. There is a 10/9/13 document from patient's pain management specialist where the provider states that after the patient's injury she went to an EMG specialist to evaluate whether there was nerve damage associated with it. The EMG showed no specific direct nerve damage. However the orthopedic surgeon after seeing x-rays and nerve conduction studies was convinced that the patient had right scapholunate dissociation of the right wrist and right ulnar neuritis of the right wrist. Subsequently, she saw an orthopedic surgeon who feels that she definitely needs surgery on her wrist. He thinks that there has been ligament tear separating the ulna from the carpal muscles, the ligaments holding that joint together have been deranged. He also feels there has been transposition of the nerve which needs to be re-localized for proper anatomy with the surgical techniques and he feels that once these procedures are done she will receive significant pain relief. She was sent to pain management because she did not feel she was getting proper medication treatment. Her chief complaints are significant wrist pain. She wears a brace most of the time that was given to her by the agreed medical evaluator. Authorization is again requested for PT. A right wrist arthrogram reveals arthritic changes in the wrist without ligamentous or cartilaginous injury other than some opacification along with the arthritis. She is scheduled to see her hand surgeon.

IMR ISSUES, DECISIONS AND RATIONALES

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

PT 2X6 RIGHT WRIST: 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 2 times per week for 6 weeks for the right wrist is not medically necessary. Per documentation patient has had extensive PT in the past and continues to have persistent pain. The most recent documentation by the orthopedic hand specialist does not see a localized anatomical issue for him to address. Furthermore, the request for 12 visits of physical therapy would exceed the MTUS guideline recommendations of up to 10 visits for this condition. The request for physical therapy 2 times per week for 6 weeks is therefore not medically necessary.

BILATERAL UPPER EXTREMITY NERVE CONDUCTION STUDIES (NCS): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007), Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 261, 270, 33. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Electrodiagnostic Studies

Decision rationale: Bilateral upper extremity nerve conduction velocity is not medically necessary per the MTUS and ODG guidelines. The American College of Occupational and Environmental Medicine (ACOEM) forearm, wrist and hand chapter states that carpal tunnel must be proved by positive findings on clinical examination and the diagnosis should be supported by nerve-conduction tests before surgery is undertaken. Furthermore, the guidelines state that appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. The ACOEM elbow chapter states that nerve conduction study and possibly EMG are appropriate if severe nerve entrapment is suspected on the basis of physical examination, denervation atrophy is likely, and there is a failure to respond to conservative treatment. The ODG states that wrist pain is not a symptom of carpal tunnel and that carpal tunnel syndrome causes digital pain and tingling in the thumb, index and long finger or numbness in the wrist. The ODG states that for ulnar neuropathy, patients who are affected with cubital tunnel syndrome often experience numbness and tingling along the little finger and ulnar half of the ring finger, usually accompanied by weakness of grip. The documentation submitted does not reveal any symptoms or findings in the left upper extremity. Additionally, the documentation submitted is not supportive of carpal tunnel syndrome, cervical radiculopathy, ulnar neuropathy at the elbow or wrist. Furthermore, the 10/10/13 documentation from the hand specialist states that for treatment the patient can use her right hand as needed within limits of discomfort and there is no anatomical problem that can be localized for him to treat with injections further surgery. The request for bilateral upper extremity nerve conduction velocity testing is not medically necessary.