

Case Number:	CM14-0100628		
Date Assigned:	08/13/2014	Date of Injury:	01/21/2014
Decision Date:	09/11/2014	UR Denial Date:	05/30/2014
Priority:	Standard	Application Received:	06/30/2014

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 and 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 33 year old male with a work injury dated 1/21/14. The diagnoses include status-post repair of right thumb laceration with tendon and vascular injuries on 1/30/14; rule out digital nerve injury of the right thumb; history of right elbow strain. Under consideration is a request for physical therapy/occupational therapy 2 to 3 times a week for 6 weeks; electromyogram of the bilateral upper extremities; nerve conduction velocity of the bilateral upper extremities. There is a primary treating physician report dated 4/28/14 that states that in total, the patient received about 15 session of post-operative therapy to his right hand from February 2014 to April 2014. He states that during physical therapy, he developed pain in his right elbow in February 2014, and he considers this industrially related. He states that overall, with surgery and therapy, he has experienced decreased pain, but he has been left with ongoing numbness, hypersensitivity, stiffness, as well as ongoing pain and restricted movement and weakness. He states that during physical therapy, he developed pain in his right elbow in February 2014, and he considers this industrially related. The patient experiences frequent moderate pain in the right elbow. There is no radiating pain from the elbow. The pain is aggravated with flexing, extending, gripping, torquing motions, driving, and rotation of the right upper extremity. There is no numbness and tingling. The patient self-restricts with the avoidance of aggravating activities. There is restricted range of motion. He has frequent to constant moderate right wrist/hand pain, with pain radiating to his thumb on the underside of his hand. He has a three to four inch scar approximately from his right thumb to his right hand. He reports having stiffness and lack of use as well as hypersensitivity in his right hand. He has numbness and tingling in his right hand and thumb. He has cramping and weakness in his right hands and has dropped several objects. His pain increases with gripping, grasping, flexing/extending, rotating, and repetitive hand and finger

movements. He reports ongoing swelling in the right hand, thumb and surgical site. On exam the bilateral elbow and shoulder exam were within normal limits. The hand exam revealed a zigzag scar along the volar proximal aspect of the right thumb. The scar is centered over the proximal phalanx volarly. The wrist range of motion is normal. There is only a toggle motion of the IP joint of the right thumb. There is sensory loss over the radial tip of the right thumb. There is a positive Tinel's sign over the radial tip of the thumb. The upper extremity strength and reflexes were normal. The treatment plan includes a request for EMG/NCV studies of the upper extremities, due to complaints of numbness and tingling. This study is necessary to assess the degree of peripheral nerve entrapment or if there is a significant nerve root lesion; an MRI of the right elbow and right hand, to rule out underlying pathology in view of failure with conservative measures and persistent of pain; and occupational hand therapy 2-3x a week for 6 weeks, based on medically reasonable treatment requirements to help regain strength, function and motion of his injured right hand. This patient has significant residual stiffness, pain and weakness.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy/Occupational Therapy 2 to 3 times a week for 6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Page(s): 99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98-99, Postsurgical Treatment Guidelines Page(s): 20.

Decision rationale: Physical Therapy/Occupational Therapy 2 to 3 times a week for 6 weeks is not medically necessary as written per the MTUS guidelines. Per the MTUS postsurgical guidelines the patient is out of the post-operative physical therapy period for this surgery of flexor tendon repair which allows up to 20 visits over 3 months with a 6 month post op time period. The patient has had at least 15 sessions of therapy. An additional 12-18 would exceed the MTUS Chronic Pain Medical Treatment Guideline recommendations for up to 10 visits. The documentation does not indicate extenuating circumstances that require 12-18 supervised therapy visits. The request for physical therapy/ Occupational Therapy 2 to 3 times a week for 6 weeks is not medically necessary.

Electromyogram of the bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 258, 178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, wrist and hand: Electrodiagnostic studies (EDS). Carpal tunnel syndrome- Electrodiagnostic studies (EDS).

Decision rationale: Electromyogram of the bilateral upper extremities is not medically necessary per the ODG and the MTUS guidelines. The ODG states that electrodiagnostic studies are recommended as an option after closed fractures of distal radius & ulna if necessary to assess nerve injury and patients with clinical signs of carpal tunnel syndrome who may be candidates for surgery. For carpal tunnel syndrome electrodiagnostic testing includes testing for nerve conduction velocities (NCV), but the addition of electromyography (EMG) is not generally necessary. The ACOEM MTUs guidelines state that electromyography (EMG) study can be performed if cervical radiculopathy is suspected as a cause of lateral arm pain, and that condition has been present for at least 6 weeks. The ACOEM also states that when the neurologic examination is less clear, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Additionally electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. The documentation submitted reveals a history and physical exam suggestive of a digital nerve injury in the right hand. The left hand has no symptoms and therefore no need to perform electrodiagnostic testing. There are no exam findings suggestive of a cervical radiculopathy or median neuropathy at the carpal tunnel. The patient did not have a distal radius or ulna fracture. The request for electromyogram of the bilateral upper extremities is not medically necessary.

Nerve Conduction Velocity of the bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 258, 178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, wrist and hand: Electrodiagnostic studies (EDS). Carpal tunnel syndrome- Electrodiagnostic studies (EDS).

Decision rationale: Nerve Conduction Velocity of the bilateral upper extremities is not medically necessary per the ODG and the MTUS guidelines. The ODG states that electrodiagnostic studies are recommended as an option after closed fractures of distal radius and ulna if necessary to assess nerve injury and patients with clinical signs of carpal tunnel syndrome who may be candidates for surgery. For carpal tunnel syndrome electrodiagnostic testing includes testing for nerve conduction velocities (NCV), but the addition of electromyography (EMG) is not generally necessary. The ACOEM MTUS guidelines state that electromyography (EMG) study can be performed if cervical radiculopathy is suspected as a cause of lateral arm pain, and that condition has been present for at least 6 weeks. The ACOEM also states that when the neurologic examination is less clear, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Additionally electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. The documentation submitted reveals a history and physical exam suggestive of a digital nerve injury in the right hand. The left hand has no symptoms and therefore no need to perform electrodiagnostic testing. There are no exam findings suggestive of a cervical radiculopathy or median neuropathy at the carpal tunnel. The

patient did not have a distal radius or ulna fracture. The request for nerve conduction velocity of the bilateral upper extremities is not medically necessary.