

Case Number:	CM14-0041012		
Date Assigned:	06/27/2014	Date of Injury:	10/17/2013
Decision Date:	08/13/2014	UR Denial Date:	02/27/2014
Priority:	Standard	Application Received:	04/01/2014

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 Occupational Medicine and is licensed to practice in California. 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 was injured on 10/17/13 in an MVA between his van and a larger truck. EMG/nerve conduction studies and an MRI of the left wrist are under review. He saw a chiropractor on 10/18/13, the day after the injury. He reported being involved in an accident the day before with a big rig. His van was pinched between the big rig and the center divide. His left hand was sore and he had neck pain, back pain, and left knee pain. He had no radicular pain. There was no swelling, stiffness, or pain at the wrist joint and no snapping or popping of the wrist. There was some stiffness of the joints of the left fingers. There was no wrist weakness. He had tenderness of the dorsal hand and palmar aspect but could make a full fist. His hand was tender. Neurologic examination was intact. He was diagnosed with a sprain of the left hand. X-rays were ordered. He was seen on 10/21/13, for neck pain that did not radiate down the arm. He still had left hand pain especially the middle and ring fingers and could not close his fist. Neurologic examination was unremarkable and nonfocal. He had a sprain of the left hand. On 10/30/13, his x-rays were reported to be negative for fracture. He was to continue with therapy. He was able to make a full fist with the left hand. It appears that he attended PT for his back. On 11/13/13, he stated he was feeling better. He wanted to continue with rehabilitation which was helping. On 11/27/13, he still stated his left hand was aching and woke him at night. Medications are not helping his left hand and wrist pain. Biofreeze was denied. He was advised to try over-the-counter Icy Hot. He still had tenderness of the hand. He could make a composite fist. He was to continue rehabilitation for his neck and back only. On 12/16/13, he had tenderness of his hands. He could make a full fist. On 01/07/14, he stated his left hand was very sore. He was to see a hand specialist but was not sure of the date. He was still seeing the chiropractor. He still had tenderness and could make a full fist. He complained of severe pain in the left hand at level 7-8/10. It was constant and radiated proximally to his fingers and palm of

the hand and was associated with throbbing, aching, and dull and popping sensations. He had limited range of motion with gripping and grasping. He had numbness, tingling, weakness, and tremors; the numbness was in his fourth and fifth fingers and comes and goes. The left wrist and hand had full range of motion with pain. He also had healing second-degree burns on both of his upper extremities and on his left lower extremity and was being treated at a burn center. He was diagnosed with left upper extremity paresthesias. An MRI of the left wrist was requested. On 04/01/14, he complained of severe pain in the hand and was dropping objects. The numbness started in his neck and radiated to between his shoulder blades and down his arm into the fingers of the hand, in particular the third and fourth fingers. He had reduced range of motion of the cervical spine. He had decreased palmar and dorsiflexion of the left hand and radial and ulnar deviation. He has positive Durkan's, Tinel's, Phalen's and mild flattening of the thenar eminence. He had loss of sensation to light touch in the third and medial aspect of the fourth digit. He was diagnosed with cervical radiculopathy and left wrist sprain with left wrist carpal tunnel syndrome. An MRI of the cervical spine was ordered. Nerve conduction study/EMG of the bilateral upper extremities was recommended. He had carpal tunnel syndrome symptoms clinically. Physical therapy and chiropractic were recommended. It is not clear whether this treatment was for the upper extremity. On 04/30/14, he had decreased left hand grip strength. Examination of the left hand, finger, and thumb revealed no signs of edema, deformity or atrophy. His finger speed appeared to be normal. Thumb to mid palm was unrestricted. Pinch test was 5/5 strength. Phalen's, Tinel's, and reverse Phalen's were negative. He had painful flexion and extension. Deep tendon reflexes were intact. Therapy was recommended. X-rays of the left hand and wrist on 05/14/14 were unremarkable. X-rays of the cervical spine were normal. His left hand pain was 0/10 but if he made a fist he got sudden sharp pain at 8/10 with numbness and tingling radiating into the third and fourth digits. He had some abnormal laboratory studies and was referred back to his PCP. He clinically had left carpal tunnel syndrome. MRIs were ordered for the cervical spine, lumbar spine, and left wrist. Acupuncture was also ordered. No MRI report for the cervical spine was reported. No focal neurologic findings demonstrating possible upper extremity radiculopathy have been documented.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Electromyography (EMG) of the Left Upper Extremity between 2/18/2014 and 4/26/2014:

Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 261. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Carpal Tunnel Syndrome, Electrodiagnostic Studies.

Decision rationale: The history and documentation do not objectively support the request for an EMG of the left upper extremity. The MTUS state criteria for ordering imaging studies are: Emergence of a red flag, Physiologic evidence of tissue insult or neurologic dysfunction, Failure

to progress in a strengthening program intended to avoid surgery, and Clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. 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 assessment may include sensory-evoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected. If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps, including the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, compute tomography [CT] for bony structures). Table 8-7 recommends EMG to identify physiologic insults or anatomic defects. The ODG state electrodiagnostic studies may be recommended in patients with clinical signs of CTS who may be candidates for surgery. Electrodiagnostic testing includes testing for nerve conduction velocities (NCV), but the addition of electromyography (EMG) is not generally necessary. In this case, there are no findings on physical examination of focal neurologic deficits that may be caused by a cervical spine problem. The medical necessity of an EMG of the left upper extremity has not been clearly demonstrated.

1 Nerve Conduction Studies (NCS) of the Left Upper Extremity between 2/18/2014 and 4/26/2014: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 261. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Carpal Tunnel Syndrome, Nerve Conduction Studies.

Decision rationale: The history and documentation do not objectively support the request for NCS of the left upper extremity. The MTUS state in cases of peripheral nerve impingement, if no improvement or worsening has occurred within four to six weeks, electrical studies may be indicated. The ODG state nerve conduction studies may be recommended in patients with clinical signs of CTS who may be candidates for surgery. Appropriate electrodiagnostic studies (EDS) include nerve conduction studies (NCS). Carpal tunnel syndrome must be proved by positive findings on clinical examination and should be supported by nerve conduction tests before surgery is undertaken. Mild CTS with normal electrodiagnostic studies (EDS) exists, but moderate or severe CTS with normal EDS is very rare. Positive EDS in asymptomatic individuals is not CTS. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. In this case, the patient has reported improvement and only has pain when he makes a fist. There is no indication

that he is likely to require surgery for carpal tunnel syndrome. The medical necessity of NCS of the left upper extremity has not been clearly demonstrated.

1 MRI of the Left Wrist between 2/18/2014 and 4/26/2014: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist, & Hand (Acute & Chronic) and Carpal Tunnel Syndrome (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Carpal Tunnel Syndrome/MRI; Forearm, Wrist, and Hand, MRI.

Decision rationale: The history and documentation do not objectively support the request for an MRI of the left wrist. The MTUS state "for most patients presenting with true hand and wrist problems, special studies are not needed until after a 4- to 6-week period of conservative care and observation." Table 11-6 states "MRI may be used to diagnose infection but is less apt to be useful in the diagnosis of carpal tunnel syndrome." The ODG state in the carpal tunnel syndrome chapter that MRI is "not recommended in the absence of ambiguous electrodiagnostic studies. Electrodiagnostic studies are likely to remain the pivotal diagnostic examination in patients with suspected CTS for the foreseeable future, but MR imaging may contribute to the diagnosis of CTS for patients with ambiguous electrodiagnostic studies and clinical examinations. Also, in the Forearm, Wrist, and Hand chapter, "indications for imaging -- Magnetic resonance imaging (MRI): Chronic wrist pain, plain film normal or equivocal, suspect Kienbock's disease." There is no evidence of a trial and failure of a reasonable course of conservative care for the left wrist/hand including an exercise program, local modalities, and the judicious use of medications. There are no new or progressive focal deficits for which this type of imaging study appears to be indicated. There is no indication of a possible tumor or that Kienbock's disease is suspected. Electrodiagnostic studies have not been done and there is no indication that they are needed prior to a trial of conservative care. Therefore, "equivocal" electrodiagnostic studies have not been reported. There is also no evidence that surgery is under consideration. The medical necessity of this request has not been clearly demonstrated.