

Case Number:	CM14-0090666		
Date Assigned:	09/10/2014	Date of Injury:	11/10/2012
Decision Date:	10/06/2014	UR Denial Date:	06/06/2014
Priority:	Standard	Application Received:	06/16/2014

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 claimant was injured on 11/10/12. An orthopedic consultation, EMG, and MRI of the bilateral wrists are under review. The claimant has chronic pain from multiple injuries and has been diagnosed with low back pain with mild multilevel disc bulging. He has a posterior annular tear at L5-S1, cervical and thoracic sprain, golfer's elbow, tennis elbow, right DeQuervain's tenosynovitis, hypertension, stress anxiety disorder and bilateral carpal tunnel syndrome. He has received acupuncture, chiropractic, PT, oral and topical medications including opiates and NSAIDs. He saw [REDACTED] and reported pain in the cervical and lumbar spines that increased with activity. He had mild bilateral wrist pain with repetitive use. There was no documentation of numbness or tingling or any neurologic deficits. On 01/10/14, he saw [REDACTED]. An MRI showed lateral epicondylitis in the left elbow and there was no change. EMG of the bilateral upper extremities was awaiting authorization. He complained of low back pain with left lower extremity radicular symptoms. He had bilateral medial epicondylitis, left lateral epicondylitis, and DeQuervain's tenosynovitis. He had had 18 chiropractic visits, 24 acupuncture visits, and 24 PT sessions with only mild improvement in his low back. He had an MRI of the left elbow. He was taking medications. There was no examination of the elbows or upper extremities. On 02/06/14, he was evaluated for bilateral medial epicondylar pain. It was decreased with ESWT and he stated he had increased strength. He had mild numbness of the left middle 3 digits. His most severe complaint was the low back pain. He was referred to [REDACTED] for EMG. He saw [REDACTED] on 02/17/14 for an electrodiagnostic medicine evaluation. He had left hand pain and bilateral arm numbness that was improved since his last evaluation. Sensory and strength were intact. He had negative Tinel's, Phalen's, and Spurling's. A nerve conduction study and EMG were normal. He had a comprehensive pain management consultation on 03/01/14. He reported pain, weakness, and numbness in his arms, back and hands. He had pain

at the medial epicondyle with tenderness and Tinel's signs were positive at the elbows. He had decreased range of motion of the elbows. Neurologic examination was intact. Only the low back was mentioned in the diagnoses. On 03/06/14, the notes states that had bilateral carpal tunnel syndrome by electrodiagnostic studies. He had an AME with [REDACTED] on 03/17/14. He stated his pain in his neck, elbows, and hands had subsided but his low back was still a problem. He had slight pain at the top of the thumbs below the wrist. His left upper extremity felt weak. There was no current clinical evidence of abnormalities in the shoulders or elbows and there was some residual pain and weakness in the left thumb status post a laceration. He had not attained maximum medical improvement. He had an ultrasound of his hands on 03/24/14. There was mild synovial thickening of the flexor pollicis longus and degenerative change of the first metacarpal head on the left side with a normal study of the right hand. On 05/29/14, [REDACTED] recommended an orthopedic consultation. On 05/27/14, he had ongoing neck and back pain and bilateral wrist pain with repetitive activities. There is scant documentation of symptoms or physical findings and an ortho referral, EMG, and MRIs were ordered.

IMR ISSUES, DECISIONS AND RATIONALES

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

Orthopedic consultation for the bilateral wrists between 05/27/2014 and 08/02/2014:

Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The history and documentation do not objectively support the request for an orthopedic consultation for the bilateral wrists between 05/27/14 and 08/02/14. The MTUS state "Referral for hand surgery consultation may be indicated for patients who: -Have red flags of a serious nature -Fail to respond to conservative management, including worksite modifications - Have clear clinical and special study evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical intervention Surgical considerations depend on the confirmed diagnosis of the presenting hand or wrist complaint. If surgery is a consideration, counseling regarding likely outcomes, risks and benefits, and, especially, expectations is very important. If there is no clear indication for surgery, referring the patient to a physical medicine practitioner may aid in formulating a treatment plan." In this case, the specific indication for an orthopedic consultation is not stated and it is not clear why surgery may be under consideration. There are no significant deficits involving the upper extremities and the claimant had reported no pain when he saw [REDACTED] for the AME. It is not clear what symptoms recurred or what diagnoses may need to be addressed by a surgeon. The medical necessity of this request for an orthopedic referral has not been clearly demonstrated.

EMG of the bilateral wrists between 05/27/2014 and 08/02/2014: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): Table 11-6.

Decision rationale: The history and documentation do not objectively support the request for EMG of the bilateral wrists. The MTUS state that EMG may be recommended during the evaluation of possible carpal tunnel syndrome. However, the claimant has already had electrodiagnostic studies and there is no evidence of new or progressive symptoms or focal neurologic deficits for which a repeat study of this type appears to be necessary. The claimant had reported resolution of his upper extremities symptoms when he saw [REDACTED] for the AME and it is not clear whether his symptoms recurred or whether he developed new symptoms. No current focal neurologic deficits have been documented. It is not clear how this study is likely to change his course of treatment. The medical necessity of this request for EMG of both wrists has not been clearly demonstrated

MRI of the bilateral wrists: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Forearm, Wrist and hand Acute and chronic

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

Decision rationale: The history and documentation do not objectively support the request for an MRI of the lumbar spine at this time. The MTUS Table 11-6 recommend MRI for the evaluation of CTS or infection. It is not clear why MRIs of both wrists have been requested in this case. There is no evidence of new or progressive deficits for which this type of imaging study appears to be indicated. There are few physical examinations of the wrists and no clear physical examination is documented on the date the studies were recommended. The specific indication for these studies has not been clearly described. Electrodiagnostic studies have been done and in March 2014, bilateral CTS was documented. There is no indication that infection is suspected. There is no evidence that urgent or emergent surgery is under consideration. The medical necessity of this request has not been clearly demonstrated.