

<b>Case Number:</b>	CM14-0189877		
<b>Date Assigned:</b>	11/21/2014	<b>Date of Injury:</b>	06/28/2011
<b>Decision Date:</b>	01/08/2015	<b>UR Denial Date:</b>	11/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/13/2014

### 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:

Injured worker (IW) accidentally stabbed himself in area of thenar eminence of left hand with a screwdriver on 06/28/11, sustaining a deep puncture wound. He also claimed injuries to multiple body areas following a fainting episode at time of injury. Hand MRI was negative. Cervical and lumbar MRIs showed degenerative changes at multiple levels. Initial upper extremity NCV studies in 2011 were normal and EMG studies were interpreted as consistent with bilateral chronic active C5-6 radiculopathy. 2011 lumbar/lower extremity EMG/NCV studies showed irritability in the upper lumbar paraspinal muscles, interpreted as consistent with degenerative disease or possible upper lumbar radicular disease at a nonspecified level. Documented treatment to date has included modified duty, medications, physical therapy, hand putty, chiropractic treatments, paraffin wax baths, electrical stimulation, and wrist support. 06/18/14 QME report did not identify a physiological pattern in IW's complaints of numbness in the entire left upper extremity. At that time a stocking distribution of bilateral lower extremity numbness was also noted. IW has been under the care of an orthopedist since 2011. 09/24/14 office note documented complaints of intractable hand pain with weakness, numbness, tingling, and waking at night. On exam there was left wrist tenderness and IW was able to make a full fist with difficulty. Sensation was reduced globally to the left hand. Tinel sign, Phalen sign, and carpal tunnel compression test were positive. 06/06/14 upper extremity EMG/NCV studies had been interpreted as normal. 11/11/14 office note documented complaints of left hand pain, numbness and tingling, as well as low back pain radiating to both lower extremities. On exam, lumbar tenderness was noted and sensation was decreased in a pattern suggesting the left L5 dermatome. Motor strength was 5/5 in the lower extremities. Both straight leg raising (SLR) and cross SLR tests were positive on the left. Per office notes, an orthopedic second opinion is requested for the left hand due to persistent symptoms and failure of conservative treatments. An orthopedic spine

consultation is requested because of persistent symptoms and for care outside current orthopedist's scope of practice.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **EMG of the left lower extremity: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303, 309.

**Decision rationale:** ACOEM Guidelines state: "Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks." The submitted documentation includes complaints of persistent low back pain radiating to the legs, with inconclusive lower extremity neurological exam and 2011 EMG studies which showed irritability in the paraspinal muscles. Performance of repeat EMG studies is reasonable in order to confirm a diagnosis of possible radiculopathy and is consistent with evidence-based recommendations. Medical necessity is established for the requested left lower extremity EMG studies.

#### **NCV of the left lower extremity: 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), Low Back Procedure Summary

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Nerve conduction studies (NCS).

**Decision rationale:** ODG states that there is "minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy." No rationale is documented which would support the medical necessity for performance of lower extremity nerve conduction studies in this case. Medical necessity is not established for the requested left lower extremity NCV studies.

#### **Spinal surgery consultation for the lumbar spine: 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), Low Back Procedure Summary

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305.

**Decision rationale:** ACOEM's Occupational Medicine Practice Guidelines 2004 edition states that "...surgical consultation is indicated for patients who have:--Severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise--Activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms--Clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair--Failure of conservative treatment to resolve disabling radicular symptomsPatients with acute low back pain alone, without findings of serious conditions or significant nerve root compromise, rarely benefit from either surgical consultation or surgery. If there is no clear indication for surgery, referring the patient to a physical medicine practitioner may help resolve the symptoms. Before referral for surgery, clinicians should consider referral for psychological screening to improve surgical outcomes, possibly including standard tests such as the second edition of the Minnesota Multiphasic Personality Inventory (MMPI-2). In addition, clinicians may look for Waddell signs during the physical exam."There is insufficient documented objective evidence of neurological compromise or a surgical condition to support the medical necessity of consultation with a spinal surgeon at this point in care. Medical necessity is not established for the requested spinal surgery consultation.

**Orthopedic second opinion for carpal tunnel syndrome:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Carpal Tunnel Syndrome Procedure Summary

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260, 270.

**Decision rationale:** ACOEM Guidelines states:"Symptoms of pain, numbness, and tingling in the hands are common in the general population, but based on studies, only about one in five symptomatic subjects would be expected to have CTS based on clinical examination and electrophysiologic testing." "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" IW has been under care of an orthopedist without improvement. Due to history of hand trauma, persistent symptoms with negative previous diagnostic evaluation, and failure of an extended course of conservative treatment, second opinion evaluation of the left hand by an orthopedic specialist is reasonable in order to confirm a diagnosis and to assist in formulating a treatment plan in this case. Medical necessity is established for the requested second opinion for carpal tunnel syndrome.