

Case Number:	CM14-0190581		
Date Assigned:	11/24/2014	Date of Injury:	12/14/2012
Decision Date:	01/09/2015	UR Denial Date:	10/15/2014
Priority:	Standard	Application Received:	11/14/2014

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:

This is a 57-year-old female with a 12/14/12 date of injury. The injury occurred when she fell and landed on her left hand/wrist regions, resulting in a crush injury. According to a transfer of primary-care-physician report dated 9/29/14, the patient complained of left hand/wrist pain with associated stiffness and grip strength weakness. She had episodes of pain with associated numbness/tingling in her left hand/fingers. Objective findings: tenderness to palpation over left dorsal wrist capsule as well as over dorsal aspect of left hand, decreased range of motion of left wrist secondary to pain, positive Phalen's test of left hand. Diagnostic impression: sprain/strain of left hand/wrist with extensor tendinitis, crush injury of left hand/wrist with residual loss of grip strength of left hand, peripheral nerve entrapment of left upper extremity and a left hand x-ray on 8/12/13 revealed mild hypertrophic changes, otherwise negative. An EMG/NCV study on 8/20/13 revealed evidence of carpal tunnel syndrome, moderate, and bilateral. No evidence of cervical radiculopathy or any other peripheral nerve compression. Treatment to date: medication management, activity modification, wrist brace. A UR decision dated 10/15/14 denied the requests for ESWT, EMG/NCV studies, interferential (IF) unit, hot/cold therapy unit, X-Ray, MRI study, FCE, acupuncture, and surgical referral. Regarding ESWT, there is no documentation of a supported condition and the ESWT is non-certified. Regarding EMG/NCV, there are no red flag signs relative to the bilateral upper extremities. The claimant has no signs of peripheral nerve entrapment, decreased subjective sensation in the left hand is not considered quantifiable peripheral neuropathy or radiculopathy. The treatment plans for the EMG test based on the results was not provided. Regarding IF unit, there is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. Regarding hot/cold therapy, the claimant did not have recent surgery and does not meet

guidelines for a hot/cold therapy unit. Regarding X-Ray and MRI, there is no specific diagnosis for the requested studies and red flag signs were not noted. There were no differential diagnoses documented. Regarding FCE, there was no documentation of prior unsuccessful return to work attempts nor does she have injuries that require detailed exploration of a worker's abilities. Regarding acupuncture, there was no indication that the claimant is actively seeking physical rehabilitation or surgical intervention for the alleged injuries. Regarding surgical referral, there is no specific diagnosis documented for the surgical referral.

IMR ISSUES, DECISIONS AND RATIONALES

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

Extracorporeal shock wave therapy - left hand, three treatments: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203, Chronic Pain Treatment Guidelines Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter - Extracorporeal Shockwave Therapy (ESWT) X Other Medical Treatment Guideline or Medical Evidence: Aetna Clinical Policy Bulletin: Extracorporeal Shock-Wave Therapy for Musculoskeletal Indications and Soft Tissue Injuries (http://www.aetna.com/cpb/medical/data/600_699/0649.html)

Decision rationale: CA MTUS and ODG do not specifically address Extracorporeal shock wave therapy of the hand. CA MTUS states that physical modalities, such as ultrasound treatment, are not supported by high-quality medical studies, but they may be useful in the initial conservative treatment of acute shoulder symptoms, depending on the experience of local physical therapists available for referral. Aetna considers extracorporeal shock-wave therapy (ESWT), extracorporeal pulse activation therapy (EPAT) (also known as extracorporeal acoustic wave therapy) experimental and investigational for the following indications (not an all-inclusive list) because there is insufficient evidence of effectiveness of ESWT for these indications in the medical literature: Achilles tendonitis (tendinopathy), Lateral epicondylitis (tennis elbow), Low back pain, Medial epicondylitis (golfers elbow), Non-unions of fractures, Osteonecrosis of the femoral head, Patellar tendinopathy, Peyronie's disease, Rotator cuff tendonitis (shoulder pain), Stress fractures, Wound healing (including burn wounds), Other musculoskeletal indications (e.g., calcaneal spur, Hammer toe, tenosynovitis of the foot or ankle, and tibialis tendinitis). However, in the present case, there is no documentation that this patient has had failure of conservative treatment measures. The requesting provider failed to establish circumstances that would warrant ESWT despite strong adverse evidence. Therefore, the request for extracorporeal shock wave therapy - left hand, three treatments was not medically necessary.

EMG and NCV studies - both upper extremities: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 238, Chronic Pain Treatment Guidelines Elbow Disorders. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back Chapter - EMG/NCV

Decision rationale: CA MTUS criteria for EMG/NCV of the upper extremity include documentation of subjective/objective findings consistent with radiculopathy/nerve entrapment that has not responded to conservative treatment. However, in the present case, the subjective numbness and tingling do not constitute radiculopathy or peripheral neuropathy. In addition, there was no documentation that the patient has failed conservative therapy. Furthermore, the patient had an EMG/NCV study done on 8/20/13. There is no documentation of interval changes since the previous study, and there is no indication on physical exam or subjective complaints, and no red flags, to support the medical necessity for a new study. Therefore, the request for EMG and NCV studies - both upper extremities is not medically necessary.

Interferential (IF) unit - 30 day trial period: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Therapy Page(s): 118-120.

Decision rationale: CA MTUS guidelines state that a one-month trial may be appropriate when pain is ineffectively controlled due to diminished effectiveness of medications; or pain is ineffectively controlled with medications due to side effects; or history of substance abuse; or significant pain from postoperative conditions limits the ability to perform; exercise programs/physical therapy treatment; or unresponsive to conservative measures. However, in the present case, there is no documentation of a history of substance abuse, medication intolerance, medication inefficacy, or medication side effects that would establish the medical necessity of this request. In addition, there is no documentation as to failure of conservative measures of treatment. Therefore, the request for interferential (IF) unit - 30 day trial period was not medically necessary.

Purchase of hot/cold therapy for home use: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Aetna Clinical Policy Bulletin: Cryoanalgesia and Therapeutic Cold (http://www.aetna.com/cpb/medical/data/200_299/0297.html)

Decision rationale: CA MTUS and ODG do not address this issue. Aetna considers the use of the Hot/Ice Machine and similar devices (e.g., the Hot/Ice Thermal Blanket, the TEC Thermoelectric Cooling System (an iceless cold compression device), the Vital Wear Cold/Hot Wrap, and the Vital Wrap) experimental and investigational for reducing pain and swelling after surgery or injury. Studies in the published literature have been poorly designed and have failed to show that the Hot/Ice Machine offers any benefit over standard cryotherapy with ice bags/packs; and there are no studies evaluating its use as a heat source. However, in the present case, there is no documentation that this patient has had a trial and failure of standard ice/heat packs. A specific rationale as to why this patient requires a hot/cold therapy unit was not provided. Therefore, the request for purchase of hot/cold therapy for home use is not medically necessary.

X-ray - left hand and wrist: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, and Hand Chapter - Radiography

Decision rationale: CA MTUS does not address this issue. According to ODG, radiography is recommended as indicated for acute hand or wrist trauma (first exam) and chronic wrist pain. For most patients with known or suspected trauma of the hand, wrist, or both, the conventional radiographic survey provides adequate diagnostic information and guidance to the surgeon. However, in the present case, the patient had a left hand x-ray on 8/12/13. There is no documentation of an acute trauma to warrant the necessity for repeat imaging. In addition, there is no indication on physical exam or subjective complaints, and no red flags, to support the medical necessity for a new study. Therefore, the request for x-ray - left hand and wrist is not medically necessary.

MRI study - left hand & wrist: 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): 254, Chronic Pain Treatment Guidelines Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, and Hand Chapter - MRI

Decision rationale: MTUS criteria for hand/wrist MRI include normal radiographs and acute hand or wrist trauma or chronic wrist pain with a suspicion for a specific pathology. However, in the present case, there are no documented subjective or objective signs of radiculopathy or nerve dysfunction and no red flag conditions. The subjective numbness and tingling do not constitute radiculopathy or peripheral neuropathy. In addition, there was no discussion or

rationale as to how the MRI study would affect the treatment plan. Furthermore, there is no documentation as to failure of conservative management. Therefore, the request for MRI study - left hand and wrist is not medically necessary.

Functional capacity evaluation - left wrist and hand: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Clinical Topics. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7 - Independent NMedical Examinations and Consultations, page(s) 132-139 Official Disability Guidelines (ODG) Fitness for Duty Chapter - FCE

Decision rationale: CA MTUS states that there is little scientific evidence confirming that FCEs predict an individual's actual capacity to perform in the workplace; an FCE reflects what an individual can do on a single day, at a particular time, under controlled circumstances, that provide an indication of that individual's abilities. In addition, ODG states that an FCE should be considered when case management is hampered by complex issues (prior unsuccessful RTW attempts, conflicting medical reporting on precautions and/or fitness for modified job), injuries that require detailed exploration of a worker's abilities, timing is appropriate (Close to or at MMI/all key medical reports secured), and additional/secondary conditions have been clarified. However, in the present case, there is no documentation of the patient's work description and what type of activity level is required at work. In addition, there is no description of the patient wanting to return to work at this time and no evidence of prior unsuccessful return-to-work attempts or noted complex issues regarding the patient's return to work. Therefore, the request for functional capacity evaluation - left wrist and hand was not medically necessary.

Acupuncture left hand and wrist, twice weekly for four weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines, Chronic Pain Treatment Guidelines Pain, Suffering, and the Restoration of Function 9792.23 Clinical Topics Page(s): 114. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, and Hand Chapter - Acupuncture

Decision rationale: CA MTUS/ACOEM guidelines stress the importance of a time-limited treatment plan with clearly defined functional goals, with frequent assessment and modification of the treatment plan based upon the patient's progress in meeting those goals, and monitoring from the treating physician is paramount. According to ODG, acupuncture for the forearm, wrist, or hand is not recommended. It is rarely used and recent systematic reviews do not recommend acupuncture when compared to placebo or control. However, in the present case, guidelines do not support acupuncture treatment for the hand and wrist. There is no documentation of other

treatment modalities that have been tried and failed. A specific rationale as to why this patient would require acupuncture treatment was not provided. Therefore, the request for acupuncture left hand and wrist, twice weekly for four weeks was not medically necessary.

Surgical referral: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Clinical Topics. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 6 - Independent Medical Examinations and Consultations, page(s) 127, 156 Official Disability Guidelines (ODG) Pain Chapter - Office Visits

Decision rationale: CA MTUS states that consultations are recommended, and a health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present or when the plan or course of care may benefit from additional expertise. However, in the present case, there is no documentation that this patient is a surgical candidate. In addition, there is no documentation that this patient has failed conservative measures of treatment to warrant surgical consideration. A specific rationale as to why this patient requires a surgical referral at this time was not provided. Therefore, the request for surgical referral is not medically necessary.