

<b>Case Number:</b>	CM14-0209123		
<b>Date Assigned:</b>	12/22/2014	<b>Date of Injury:</b>	04/15/2004
<b>Decision Date:</b>	02/13/2015	<b>UR Denial Date:</b>	11/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/15/2014

### 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 Rehab, has a subspecialty in Interventional Spine, 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 is a 62 year old male with an injury date of 04/15/04. Based on the 10/22/14 progress report provided by treating physician, the patient complains of left inguinal pain, bilateral leg numbness with weakness in foot, increased bilateral hand pain and numbness in the right hand. Additionally, patient complains of difficulty sleeping, anxiety, and loud snoring. Patient is status post open reduction of the left ankle on 09/04[sic], has medical history of Polio at age 5. Physical examination 10/22/14 notes that patient walks with a marked limp, left foot drop, left quadriceps atrophy and general weakness to the left lower extremity with associated parasthesia and numbness to the left thigh. JAMAR hand grip strength diagnostic tool reports values of 55, 55, 56 (mean 55.3) to the right upper extremity, 55, 50, 45 (mean 50) to the left upper extremity. Positive Tinel's sign and positive Phalen's sign are noted (though which extremity is not specified). Per progress report dated 06/18/14 the patient is currently taking Aspirin, pain medications (unspecified), and oral anti-hypertensive medication (unspecified). EMG/NCV conducted 05/10/10 of bilateral upper extremities noted: "mild right CTS (median nerve entrapment at wrist) affecting sensory components. This electrodiagnostic study reveals no evidence of ulnar entrapment neuropathy, radial entrapment neuropathy, and cervical radiculopathy." Per progress report dated 11/20/14 patient is advised to remain sedentary for 4 months. Diagnosis 11/06/14- Left thigh infected lesion with pain- S/P 9/04 open reduction of left ankle, requires hardware removal- Left lower extremity weakness, ataxia- Left meralgia parasthetica - Ehlers-Danlos syndrome- Rule out carpal tunnel syndrome- Rule out OSAThe utilization review determination being challenged is dated 11/15/14. The rationale follows: 1) EDX of bilateral upper extremities: "The submitted documentation reported that the patient had a previous EMG/NCV on 07/19/2011 that revealed normal NCV and EMG findings of old residual moderate polio on the left side only and the right side was within normal limits. Although the

patient had numbness in the hand, there was no indication that the patient was suffering from carpal tunnel syndrome on examination other than positive Tinel's and Phalen's test."2)

Polysomnogram: "Although the patient reported snoring and sleeping too much, the patient does not qualify for a polysomnogram based on the cited guideline criteria. There should have been evidence of a sleep complaint for at least 6 months, with failure of behavior intervention and sedative/sleep promoting medications, and after psychiatric etiology has been excluded."

Treatment reports were provided from 03/26/14 to 11/20/14.

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

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

### **1 EDX of bilateral upper extremities: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 261.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260-262.

**Decision rationale:** The patient presents with increased bilateral hand pain and numbness in the right hand. Patient is status post open reduction of the left ankle on 09/04[sic], has medical history of Polio at age 5. The request is for 1 EDX of bilateral upper extremities. Physical examination 10/22/14 JAMAR hand grip strength diagnostic tool reports values of 55, 55, 56 (mean 55.3) to the right upper extremity, 55, 50, 45 (mean 50) to the left upper extremity. Positive Tinel's sign and positive Phalen's sign are noted (though which extremity is not specified). Per progress report dated 06/18/14 the patient is currently taking Aspirin, pain medications (unspecified), and oral anti-hypertensive medication (unspecified). EMG/NCV conducted of bilateral upper extremities dated 05/10/10 was included with the report. Per progress report dated 11/20/14, patient is advised to remain sedentary for 4 months. ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11, pages 260-262 state: "Appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful. NCS and EMG may confirm the diagnosis of CTS but may be normal in early or mild cases of CTS. If the EDS are negative, tests may be repeated later in the course of treatment if symptoms persist." Per progress report dated 10/22/14, the patient exhibits decreased grip strength bilaterally as demonstrated by mean JAMAR hand grip diagnostic values of 50 for the left hand and 55.3 to the right (normal values for a 62 year old male are 76.8 and 89.7, respectively), indicating approximately 34 percent loss of strength in the left hand and 38 percent loss in the right. The last electrodiagnostic study performed on the upper extremities was dated 05/10/10 and symptoms continue to persist. ACOEM guidelines indicate that it is appropriate to repeat electrodiagnostic studies should symptoms persist, although the precise interval is not specified. Additionally, per 10/22/14 physical examination patient exhibits positive Tinel's sign and positive Phalen's sign, which can be indicative of carpal tunnel syndrome. Given the loss of grip strength bilaterally, persistence of symptoms since last exam, and positive physical findings, this request appears to be reasonable in order to rule out cervical radiculopathy. The request is medically necessary.

## **1 Polysomnogram: 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), Pain, Criteria for Polysomnography

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter Pain (chronic), Polysomnography.

**Decision rationale:** The patient presents with difficulty sleeping, anxiety, and loud snoring. The request is for 1 polysomnogram. No objective findings pertinent to sleep complaint were included with the report beyond subjective complaints of snoring and excessive sleeping. ODG-TWC guidelines, chapter 'Pain (chronic)' and topic 'Polysomnography', list the following criteria for Polysomnography: "Polysomnogram / sleep studies are recommended for the combination of indications listed below: (1) Excessive daytime somnolence; (2) Cataplexy (muscular weakness usually brought on by excitement or emotion, virtually unique to narcolepsy); (3) Morning headache (other causes have been ruled out); (4) Intellectual deterioration (sudden, without suspicion of organic dementia); (5) Personality change (not secondary to medication, cerebral mass or known psychiatric problems); & (6) Insomnia complaint for at least six months (at least four nights of the week), unresponsive to behavior intervention and sedative/sleep-promoting medications and psychiatric etiology has been excluded. A sleep study for the sole complaint of snoring, without one of the above mentioned symptoms, is not recommended." In regards to the request for a polysomnogram comprehensive sleep study, the progress notes dated 10/22/14 provide subjective complaints of excessive daytime somnolence in addition to snoring and insomnia, although the true extent and duration of the insomnia episodes are not specifically discussed. A careful review of the reports provided fails to identify further symptoms warranting polysomnography, namely: symptoms of cataplexy, morning headache, intellectual deterioration, or personality change. Additionally, there is no documentation of the failure of sedative/sleep promoting medications to produce appreciable benefit and psychiatric etiology is also not addressed. The documentation provided fails to fully address the criteria required to establish the necessity of polysomnography for this patient. Therefore, this request is not medically necessary.