

Case Number:	CM14-0027628		
Date Assigned:	06/13/2014	Date of Injury:	09/27/2012
Decision Date:	02/25/2015	UR Denial Date:	02/27/2014
Priority:	Standard	Application Received:	03/04/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California
 Certification(s)/Specialty: Internal Medicine

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 an injured worker with a history of sprain and strain of the right wrist, right hand ligament tear, and right fifth digit surgery 12/11/12. The date of injury was 09/27/12. The patient was injured when a sheet fell on the patient's right hand, wrist, fifth finger, and right foot. The patient underwent right fifth digit surgery. The primary treating physician's progress report dated 02/03/14 documents that the patient complains of sharp burning pain in the right hand and fifth digit. There are complaints of muscle spasms, weakness, numbness and tingling of the hand and fingers. There is constant and moderate to severe pain. The patient notes that the symptoms persist but the medications do offer temporarily relief of pain and improve the ability to have restful sleep. The pain is also alleviated with activity restrictions. It is noted that the patient had a consultation with a hand specialist and was advised to undergo surgery. On physical examination, there is deformity of the fifth digit and tenderness of the fifth digit at the metacarpal, proximal interphalangeal and distal phalangeal joints. There is full range of motion for the right wrist, metacarpal joints and 5th digit. For the proximal and distal phalangeal joints range of motion is 0 degrees for flexion and extension and there is a mallet deformity distally. Tinel's and Phalen's tests are negative. Sensation is intact in the right upper extremity. Motor strength is decreased in the right upper extremity. Diagnoses were sprain and strain of the right wrist, right hand ligament tear, and right fifth digit surgery 12/11/12. Treatment plan was documented. The provider recommends a referral to a psychologist, a return appointment in four weeks, and to remain off of work. The provider is requesting an electromyography (EMG) and

nerve conduction velocity (NCV) of the right upper extremity and shockwave therapy of the right hand.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG of the right upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-269.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): Pages 269, 272. Decision based on Non-MTUS Citation Forearm, Wrist, & Hand (Acute & Chronic) Electrodiagnostic studies (EDS); Carpal Tunnel Syndrome (Acute & Chronic) Electrodiagnostic studies (EDS), Electromyography (EMG)

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses electrodiagnostic studies. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 11 Forearm, Wrist, and Hand Complaints (Page 272) indicates that routine use of NCV or EMG in diagnostic evaluation of nerve entrapment or screening in patients without symptoms is not recommended. NCV for median (B) or ulnar (C) impingement at the wrist after failure of conservative treatment is recommended. ACOEM Table 11-6 Ability of Various Techniques To Identify and Define Forearm, Wrist, and Hand Pathology (Page 269) indicates that electromyography and nerve conduction velocity (EMG/NCV) testing has no ability to identify and define pathology for ligament strain, tendon strain, tendinitis, or tenosynovitis. Official Disability Guidelines (ODG) indicates that electrodiagnostic studies (EDS) is Recommended in patients with clinical signs of CTS carpal tunnel syndrome 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. Poor overlap between various screening procedures warns against the use of electrodiagnostic findings alone without also considering the symptom presentation. Nerve conduction studies (NCS) is recommended in patients with clinical signs of CTS carpal tunnel syndrome who may be candidates for surgery. Carpal tunnel syndrome must be proved by positive findings on clinical examination. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Electromyography (EMG) is recommended only in cases where diagnosis is difficult with nerve conduction studies (NCS). In more difficult cases, needle electromyography (EMG) may be helpful as part of electrodiagnostic studies which include nerve conduction studies (NCS). Seldom is it required that both studies be accomplished in straightforward condition of median and ulnar neuropathies or peroneal nerve compression neuropathies. The primary treating physician's progress report dated February 3, 2014 documented negative Tinel's sign, negative Phalen's sign and intact sensation. Diagnoses were right wrist sprain and strain and right hand ligament tear. Nerve entrapment is not evidenced. No evidence of median or ulnar impingement at the wrist was demonstrated. No diagnosis of carpal tunnel syndrome was documented. ACOEM 2nd Edition (2004) Chapter 11 Forearm, Wrist, and Hand Complaints (Page 269) indicates that electromyography and nerve conduction velocity (EMG/NCV) testing has no ability to identify

and define pathology for ligament strain, tendon strain, tendinitis, or tenosynovitis. The request for EMG/NCV is not supported by MTUS, ACOEM, or ODG guidelines. Therefore, the request for electromyography EMG of the right upper extremity is not medically necessary.

NCV of the right upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-269.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): Pages 269, 272. Decision based on Non-MTUS Citation Forearm, Wrist, & Hand (Acute & Chronic) Electrodiagnostic studies (EDS); Carpal Tunnel Syndrome (Acute & Chronic) Electrodiagnostic studies (EDS), Electromyography (EMG)

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses electrodiagnostic studies. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 11 Forearm, Wrist, and Hand Complaints (Page 272) indicates that routine use of NCV or EMG in diagnostic evaluation of nerve entrapment or screening in patients without symptoms is not recommended. NCV for median (B) or ulnar (C) impingement at the wrist after failure of conservative treatment is recommended. ACOEM Table 11-6 Ability of Various Techniques To Identify and Define Forearm, Wrist, and Hand Pathology (Page 269) indicates that electromyography and nerve conduction velocity (EMG/NCV) testing has no ability to identify and define pathology for ligament strain, tendon strain, tendinitis, or tenosynovitis. Official Disability Guidelines (ODG) indicates that electrodiagnostic studies (EDS) is Recommended in patients with clinical signs of CTS carpal tunnel syndrome 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. Poor overlap between various screening procedures warns against the use of electrodiagnostic findings alone without also considering the symptom presentation. Nerve conduction studies (NCS) is recommended in patients with clinical signs of CTS carpal tunnel syndrome who may be candidates for surgery. Carpal tunnel syndrome must be proved by positive findings on clinical examination. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Electromyography (EMG) is recommended only in cases where diagnosis is difficult with nerve conduction studies (NCS). In more difficult cases, needle electromyography (EMG) may be helpful as part of electrodiagnostic studies which include nerve conduction studies (NCS). Seldom is it required that both studies be accomplished in straightforward condition of median and ulnar neuropathies or peroneal nerve compression neuropathies. The primary treating physician's progress report dated February 3, 2014 documented negative Tinel's sign, negative Phalen's sign and intact sensation. Diagnoses were right wrist sprain and strain and right hand ligament tear. Nerve entrapment is not evidenced. No evidence of median or ulnar impingement at the wrist was demonstrated. No diagnosis of carpal tunnel syndrome was documented. ACOEM 2nd Edition (2004) Chapter 11 Forearm, Wrist, and Hand Complaints (Page 269) indicates that electromyography and nerve conduction velocity (EMG/NCV) testing has no ability to identify and define pathology for ligament strain, tendon strain, tendinitis, or tenosynovitis. The request for EMG/NCV is not supported by MTUS, ACOEM, or ODG guidelines. Therefore, the request

for nerve conduction velocity NCV of the right upper extremity is not medically necessary. Medical Treatment Utilization Schedule (MTUS) addresses electrodiagnostic studies. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 11 Forearm, Wrist, and Hand Complaints (Page 272) indicates that routine use of NCV or EMG in diagnostic evaluation of nerve entrapment or screening in patients without symptoms is not recommended. NCV for median (B) or ulnar (C) impingement at the wrist after failure of conservative treatment is recommended. ACOEM Table 11-6 Ability of Various Techniques To Identify and Define Forearm, Wrist, and Hand Pathology (Page 269) indicates that electromyography and nerve conduction velocity (EMG/NCV) testing has no ability to identify and define pathology for ligament strain, tendon strain, tendinitis, or tenosynovitis. Official Disability Guidelines (ODG) indicates that electrodiagnostic studies (EDS) is Recommended in patients with clinical signs of CTS carpal tunnel syndrome 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. Poor overlap between various screening procedures warns against the use of electrodiagnostic findings alone without also considering the symptom presentation. Nerve conduction studies (NCS) is recommended in patients with clinical signs of CTS carpal tunnel syndrome who may be candidates for surgery. Carpal tunnel syndrome must be proved by positive findings on clinical examination. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Electromyography (EMG) is recommended only in cases where diagnosis is difficult with nerve conduction studies (NCS). In more difficult cases, needle electromyography (EMG) may be helpful as part of electrodiagnostic studies which include nerve conduction studies (NCS). Seldom is it required that both studies be accomplished in straightforward condition of median and ulnar neuropathies or peroneal nerve compression neuropathies. The primary treating physician's progress report dated February 3, 2014 documented negative Tinel's sign, negative Phalen's sign and intact sensation. Diagnoses were right wrist sprain and strain and right hand ligament tear. Nerve entrapment is not evidenced. No evidence of median or ulnar impingement at the wrist was demonstrated. No diagnosis of carpal tunnel syndrome was documented. ACOEM 2nd Edition (2004) Chapter 11 Forearm, Wrist, and Hand Complaints (Page 269) indicates that electromyography and nerve conduction velocity (EMG/NCV) testing has no ability to identify and define pathology for ligament strain, tendon strain, tendinitis, or tenosynovitis. The request for EMG/NCV is not supported by MTUS, ACOEM, or ODG guidelines. Therefore, the request for nerve conduction velocity NCV of the right upper extremity is not medically necessary.

Shockwave Therapy (Right Hand, Right 5th Digit): 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): 265, 271.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses passive modalities. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 11 Forearm, Wrist, and Hand Complaints (Page 272) indicates that

physical modalities, such as massage, diathermy, cutaneous laser treatment, cold laser treatment, transcutaneous electrical neurostimulation (TENS) units, and biofeedback have no scientifically proven efficacy in treating acute hand, wrist, or forearm symptoms. Table 11-7 Summary of Recommendations for Evaluating and Managing Forearm, Wrist, and Hand Complaints indicates that passive modalities are not recommended. No randomized controlled trials that support the effectiveness of the extracorporeal shock wave therapy (ESWT) for hand conditions were discovered with U.S. National Library of Medicine PubMed.gov. The request for extracorporeal shockwave therapy for the right hand is not supported by ACOEM guidelines. Therefore, the request for shockwave therapy for the right hand and right fifth digit is not medically necessary.