

<b>Case Number:</b>	CM15-0148276		
<b>Date Assigned:</b>	08/11/2015	<b>Date of Injury:</b>	02/24/2014
<b>Decision Date:</b>	09/08/2015	<b>UR Denial Date:</b>	07/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/30/2015

### 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: Physical Medicine & Rehabilitation, Pain Management

### 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 28 year old male with a February 24, 2014 date of injury. A progress note dated June 29, 2015 documents subjective complaints (pain and discomfort in the bilateral wrists and forearms; some numbness and tingling in the hand), objective findings (local tenderness and swelling; tenderness noted in the wrists and elbows bilaterally; full range of motion; positive Tinel's and Phalen's signs), and current diagnoses (repetitive strain injury; bilateral wrist tendonitis; bilateral wrist strain). Treatments to date have included home exercise, electrodiagnostic study in January of 2013 that was negative for any nerve entrapment; acupuncture, electrodiagnostic study in March of 2015 that showed carpal tunnel syndrome, and work restrictions. The treating physician documented a plan of care that included magnetic resonance imaging of the bilateral wrists and forearms, and electromyogram-nerve conduction studies of the bilateral upper extremities.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI Bilateral wrists and Bilateral forearms:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 269. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist and Hand-MRIs.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 269. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, and Hand and Carpal Tunnel Syndrome Chapters, MRI.

**Decision rationale:** Regarding the request for MRI of wrist and forearms (bilateral), ACOEM Chapter 11 on pages 268-269 state the following regarding wrist/hand imaging studies: For most patients presenting with true hand and wrist problems, special studies are not needed until after a four-to six-week period of conservative care and observation. Most patients improve quickly, provided red flag conditions are ruled out. Exceptions include the following: In cases of wrist injury, with snuff box (radial-dorsal wrist) tenderness, but minimal other findings, a scaphoid fracture may be present. Initial radiographic films may be obtained but may be negative in the presence of scaphoid fracture. A bone scan may diagnose a suspected scaphoid fracture with a very high degree of sensitivity, even if obtained within 48 to 72 hours following the injury. An acute injury to the metacarpophalangeal joint of the thumb, accompanied by tenderness on the ulnar side of the joint and laxity when that side of the joint is stressed (compared to the other side), may indicate a gamekeeper thumb or rupture of the ligament at that location. Radiographic films may show a fracture; stress views, if obtainable, may show laxity. The diagnosis may necessitate surgical repair of the ligament; therefore, a surgical referral is warranted. In cases of peripheral nerve impingement, if no improvement or worsening has occurred within four to six weeks, electrical studies may be indicated. The primary treating physician may refer for a local Lidocaine injection with or without corticosteroids. Recurrence of a symptomatic ganglion that has been previously aspirated or a trigger finger that has been previously treated with local injections (see Table 11-4) is usually an indication for re-aspiration or referral, based on the treating physician's judgment. A number of patients with hand and wrist complaints will have associated disease such as diabetes, hypothyroidism, Vitamin B complex deficiency and arthritis. When history indicates, testing for these or other comorbid conditions is recommended. If symptoms have not resolved in four to six weeks and the patient has joint effusion, serologic studies for Lyme disease and autoimmune diseases may be indicated. Imaging studies to clarify the diagnosis may be warranted if the medical history and physical examination suggest specific disorders. Within the documentation available for review, there is documentation of continued pain beyond 4-6 weeks. However, the most recent progress note associated with this request did not document any specific rationale as to what pathology was being sought. Given this lack of documentation, this request is not medically necessary.

**EMG/NCS Bilateral upper extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Electrodiagnostic studies.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 271-3. Decision based on Non-MTUS Citation Official Disability

Guidelines (ODG) Carpal Tunnel Syndrome Chapter, Electrodiagnostic Studies Neck and Upper Back Chapter, Electrodiagnostic Studies.

**Decision rationale:** Regarding the request for EMG and NCS of the upper extremities, ACOEM Practice Guidelines state that the electromyography may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. Within the documentation available for review, there is documentation of provocative maneuvers suggesting nerve entrapment. There is a prior electrodiagnostic study in March 2015. This demonstrated carpal tunnel syndrome and there is no commentary as to why a second EMG/NCS would be necessary at this time. The current request is not medically necessary.