

Case Number:	CM15-0195682		
Date Assigned:	10/09/2015	Date of Injury:	10/15/2014
Decision Date:	12/11/2015	UR Denial Date:	09/11/2015
Priority:	Standard	Application Received:	10/05/2015

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: Emergency 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:

This is a 35 year old female with a date of injury 10-15-14. A review of the medical records indicates that the injured worker is undergoing treatment for upper extremities and lower back. Progress report dated 9-1-15 reports follow up to surgery of right wrist on 6-19-15. She completed 12 sessions of physical therapy helped her improve her swelling, range of motion and function. The pain continues and more physical therapy is recommended since the symptoms went back to before surgery. Range of motion has decreased, swelling and worsening numbness and tingling in the 4th and 5th digit of the right hand. Objective findings: moderate swelling of the right wrist and hand, tender to palpation of the right wrist, sensation reduced in the 4th and 5th digits of the right hand, range of motion is restricted. Treatments include: medication, physical therapy, surgery. Request for authorization dated 9-1-15 was made for physical therapy 3 times per week for 4 weeks, EMG upper extremity and lower extremity and nerve conduction studies of left upper extremities. Utilization review dated 9-11-15 modified physical therapy to certify 6 visits of physical therapy and non-certified EMG and nerve conduction studies.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy; twelve (12) sessions (3x4): Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment 2009, Section(s): Forearm, Wrist, & Hand.

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, & Hand (Acute & Chronic)/Physical/Occupational therapy.

Decision rationale: The request is for physical therapy. The official disability guidelines state the following regarding this topic: ODG Physical/Occupational Therapy Guidelines: Allow for fading of treatment frequency (from up to 3 visits or more per week to 1 or less), plus active self-directed home PT. More visits may be necessary when grip strength is a problem, even if range of motion is improved. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface. Fracture of carpal bone (wrist) (ICD9 814):Medical treatment: 8 visits over 10 weeks Post-surgical treatment: 16 visits over 10 weeks Fracture of metacarpal bone (hand) (ICD9 815):Medical treatment: 9 visits over 3 weeks Post-surgical treatment: 16 visits over 10 weeks Fracture of one or more phalanges of hand (fingers) (ICD9 816):Minor, 8 visits over 5 weeks Post-surgical treatment: Complicated, 16 visits over 10 weeks Fracture of radius/ulna (forearm) (ICD9 813):Medical treatment: 16 visits over 8 weeks Post-surgical treatment: 16 visits over 8 weeks Dislocation of wrist (ICD9 833):Medical treatment: 9 visits over 8 weeks Post-surgical treatment (TFCC reconstruction): 16 visits over 10 weeks Dislocation of finger (ICD9 834):9 visits over 8 weeks Post-surgical treatment: 16 visits over 10 weeks Trigger finger (ICD9 727.03):Post-surgical treatment: 9 visits over 8 weeks Radial styloid tenosynovitis (de Quervain's) (ICD9 727.04):Medical treatment: 12 visits over 8 weeks Post-surgical treatment: 14 visits over 12 weeks Synovitis and tenosynovitis (ICD9 727.0):Medical treatment: 9 visits over 8 weeks Post-surgical treatment: 14 visits over 12 weeks Mallet finger (ICD9 736.1)16 visits over 8 weeks Contracture of palmar fascia (Dupuytren's) (ICD9 728.6):Post-surgical treatment: 12 visits over 8 weeks Ganglion and cyst of synovium, tendon, and bursa (ICD9 727.4):Post-surgical treatment: 18 visits over 6 weeks9 visits over 8 weeks In this case, the number of requested treatments is not guideline-supported. As indicated above for post-surgical ganglion cyst excision, 18 total visits over 6 weeks are advised. The patient therefore would be certified for 6 more treatments. As such, the request as written is not medically necessary.

NCS of the left upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist & Hand, Electrodiagnostic studies (EDS).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and upper back/Nerve conduction studies.

Decision rationale: The request is for nerve conduction studies. The MTUS guidelines are silent regarding this issue. The ODG states the following: Not recommended to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious

clinical signs, but recommended if the EMG is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely based on the clinical exam. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy. (Utah, 2006) (Lin, 2013) While cervical electrodiagnostic studies are not necessary to demonstrate a cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality, diabetic neuropathy, or some problem other than a cervical radiculopathy, with caution that these studies can result in unnecessary over treatment. (Emad, 2010) (Plastaras, 2011) (Lo, 2011) (Fuglsang-Frederiksen, 2011) See also the Shoulder Chapter, where nerve conduction studies are recommended for the diagnosis of TOS (thoracic outlet syndrome). Also see the Carpal Tunnel Syndrome Chapter for more details on NCS. Studies have not shown portable nerve conduction devices to be effective. In this case, the use of this diagnostic test is not supported. This is secondary to poor documentation of peripheral nerve compromise necessitating further clarity. There is also inadequate discussion of how the result of this study would change the clinical management. Pending receipt of this information, the request is not medically necessary.

EMG of the right upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist & Hand, Electrodiagnostic studies (EDS).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and upper back/EMGs (electromyography).

Decision rationale: Recommended (needle, not surface) as an option in selected cases. The American Association of Electrodiagnostic Medicine conducted a review on electrodiagnosis in relation to cervical radiculopathy and concluded that the test was moderately sensitive (50%-71%) and highly specific (65%-85%). (AAEM, 1999) EMG findings may not be predictive of surgical outcome in cervical surgery, and patients may still benefit from surgery even in the absence of EMG findings of nerve root impingement. This is in stark contrast to the lumbar spine where EMG findings have been shown to be highly correlative with symptoms. Indications when particularly helpful: EMG may be helpful for patients with double crush phenomenon, in particular, when there is evidence of possible metabolic pathology such as neuropathy secondary to diabetes or thyroid disease, or evidence of peripheral compression such as carpal tunnel syndrome. In this case, the patient does not meet criteria for the study requested. This is secondary to poor physical exam findings suggestive of peripheral nerve compression. Pending receipt of information further clarifying how this study would change the management rendered, the study is not medically necessary.

EMG of the left upper extremity: Upheld

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