

Case Number:	CM15-0203264		
Date Assigned:	10/20/2015	Date of Injury:	03/10/2004
Decision Date:	12/16/2015	UR Denial Date:	09/21/2015
Priority:	Standard	Application Received:	10/15/2015

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: Maryland, Virginia, North Carolina
 Certification(s)/Specialty: Plastic Surgery

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 injured worker is a 77 year old male, who sustained an industrial-work injury on 3-10-04. A review of the medical records indicates that the injured worker is undergoing treatment for right carpal tunnel syndrome and bilateral cubital tunnel syndrome. Treatment to date has included pain medication, orthopedic consult, and work modifications. Medical records dated 8-7-15 indicate that the injured worker complains of numbness, tingling and weakness in the bilateral hands with the right worse than the left. Per the treating physician report dated 8-7-15 the injured worker is retired. The physical exam dated 8-7-15 reveals that there is full range of motion in the wrists, there are degenerative findings in the small joints of both hands, and there is decreased sensation to light touch in all fingers of the bilateral upper extremities. There is positive Tinel's at the bilateral wrists and bilateral cubital tunnel areas. Phalen's tests are positive at the bilateral wrists. The right grip strength is less than the left. The physician indicates that he has failed anti-inflammatories, rest and bracing and has numbness and pain in the hands with progressive weakness. The electrodiagnostic tests were positive in 2004. The requested services included Associated surgical service: Follow up x-rays, Associated surgical service, TENs with supplies x 6 months, and Associated surgical service: Physical therapy 2 times a week for 6 weeks. The original Utilization review dated 9-21-15 non-certified the request for associated surgical service: Follow up x-rays and associated surgical service: TENs with supplies x 6 months. The request for associated surgical service: Physical therapy 2 times a week for 6 weeks was modified to associated surgical service: Physical therapy 2 times a week for 4 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical service: Follow up x-rays: Overturned

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Special Studies.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies.

Decision rationale: The patient is a 77 year old male with a history of neck and shoulder pain, as well as weakness of the bilateral hands. Examination noted cervical spine tenderness and mildly decreased cervical lordosis. Examination of the shoulders revealed decreased range of motion and pain. Examination of the bilateral hands revealed evidence of signs and symptoms of bilateral carpal tunnel syndrome and degenerative findings in the small joints of the hands. A request had been made for follow-up X-rays. Given the findings on subjective and objective evaluations and based on the history of cumulative trauma for this patient with failure of conservative management, follow-up X-rays should be considered medically necessary. From ACOEM, Chapter pages 177-179 for most patients presenting with true neck or upper back problems, special studies are not needed unless a three- or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out. Criteria for ordering imaging studies are: Emergence of a red flag. Physiologic evidence of tissue insult or neurologic dysfunction. Failure to progress in a strengthening program intended to avoid surgery. Clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. The assessment may include sensory-evoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected. If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps, including the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, compute tomography [CT] for bony structures). Additional studies may be considered to further define problem areas. The recent evidence indicates cervical disk annular tears may be missed on MRIs. The clinical significance of such a finding is unclear, as it may not correlate temporally or anatomically with symptoms. Diskography is frequently used prior to cervical fusions and certain disk related procedures. There is significant scientific evidence that questions the usefulness of diskography in those settings. While recent studies indicate diskography to be relatively safe and have a low complication rate, some studies suggest the opposite to be true. In any case, clear evidence is lacking to support its efficacy over other imaging procedures in identifying the location of cervical symptoms, and, therefore, directing intervention

appropriately. Tears may not correlate anatomically or temporally with symptoms. Because this area is rapidly evolving, clinicians should consult the latest available studies. Table 8-7 provides a general comparison of the abilities of different techniques to identify physiologic insult and define anatomic defects. In the following circumstances, an imaging study may be appropriate for a patient whose limitations due to consistent symptoms have persisted for four to six weeks or more: When surgery is being considered for a specific anatomic defect to further evaluate the possibility of potentially serious pathology, such as a tumor Reliance on imaging studies alone to evaluate the source of neck or upper back symptoms carries a significant risk of diagnostic confusion (false-positive test results) because it's possible to identify a finding that was present before symptoms began and, therefore, has no temporal association with the symptoms. The request for X-rays is medically necessary.

Associated surgical service; TENs with supplies x 6 months: 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), Forearm, Wrist & Hand (updated 06/29/2015), Online Version TENS (transcutaneous electrical neurostimulation).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: Based on the documentation provided, it does not appear that the patient had undergone a 1-month trial with TENS. According to the Chronic Pain Medical Treatment 2009 Guidelines, TENS (transcutaneous electrical nerve stimulation) for chronic pain is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for the conditions described below. Therefore, the request exceeds guideline recommendations of a 1-month trial and is not medically necessary.

Associated surgical service: Physical therapy 2 times a week for 6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment 2009, Section(s): Carpal Tunnel Syndrome.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment 2009, Section(s): Carpal Tunnel Syndrome.

Decision rationale: The patient is a 77 year old male who was certified for a right carpal tunnel release. He had signs and symptoms of right carpal tunnel syndrome that had been supported by previous examination findings. A request had been made for 12 post operative physical therapy visits. Postoperative physical therapy should be considered based on the following guidelines: From page 15 and 16, there is limited evidence demonstrating the effectiveness of PT (physical therapy) or OT (occupational therapy) for CTS (carpal tunnel syndrome). The evidence may justify 3 to 5 visits over 4 weeks after surgery, up to the maximums shown below. Benefits need to be documented after the first week, and prolonged therapy visits are not supported. Carpal

tunnel syndrome should not result in extended time off work while undergoing multiple therapy visits, when other options (including surgery for carefully selected patients) could result in faster return to work. Furthermore, carpal tunnel release surgery is a relatively simple operation that also should not require extended multiple therapy office visits for recovery. Carpal tunnel syndrome (ICD9 354.0): Postsurgical treatment (endoscopic): 3-8 visits over 3-5 weeks. Postsurgical physical medicine treatment period: 3 months Postsurgical treatment (open): 3-8 visits over 3-5 weeks. Postsurgical physical medicine treatment period: 3 months From page 10, an initial course of therapy means one half of the number of visits specified in the general course of therapy for the specific surgery in the postsurgical physical medicine treatment recommendations set forth in subdivision (d) (1) of this section. Therefore, based on these guidelines, 12 visits would exceed the initial course of therapy guidelines and is not medically necessary.