MAXIMUS Federal Services

Case Number:	CM15-0127279		
Date Assigned:	07/20/2015	Date of Injury:	12/14/2012
Decision Date:	08/31/2015	UR Denial Date:	06/05/2015
Priority:	Standard	Application Received:	07/01/2015

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: New York
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 injured worker is a 57 year old female with an industrial injury dated 12/14/2012. The injured worker's diagnoses include sprain/strain of left hand/wrist with extensor tendinitis, crush injury of left hand/wrist with residual loss of grip strength of left hand, and left upper extremity peripheral nerve entrapment. Treatment consisted of diagnostic studies, prescribed medications, and periodic follow up visits. In a progress note dated 12/04/2014, the injured worker reported intermittent to frequent episodes of left hand/wrist pain with associated stiffness, grip strength weakness and associated numbness/tingling in her left hand/fingers. Objective findings revealed left grip strength limited by pain, left upper extremity tenderness to palpitation over the injured worker's left dorsal wrist capsule, and decreased range of motion. The treating physician prescribed services for extracorporeal shockwave therapy left hand/wrist times 3, Electromyography (EMG) and nerve conduction velocity (NCV) of the upper extremity, Interferential (IF) unit for a 30 day trial, Hot/cold therapy home use purchase, X-ray for left hand/wrist, Functional capacity evaluation (FCE), Acupuncture left hand/wrist 2 times per week for 4 weeks, MRI for left hand/wrist and overnight sleep study now under review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Extracorporeal shockwave therapy left hand/wrist times 3: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Journal of Orthopaedic Surgery and Research 7.1 (2012) pages 1-8, Up-to-date--Extracorporeal shockwave therapy.

Decision rationale: CA MTUS and ODG do not address this therefore alternate guidelines including Up-to-date were reviewed. Extracorporeal shockwave therapy is primarily used for sports-related overuse tendinopathies that include plantar fascitis, lateral epicondylitis, shoulder and patellar tendinopathy. The injured worker's diagnoses include sprain/strain of left hand/wrist with extensor tendinitis, crush injury of left hand/wrist with residual loss of grip strength of left hand, and left upper extremity peripheral nerve entrapment. This injured worker's injury is not noted to be from overuse. Also this procedure is not recommended for hand/wrist. Based on the currently available medical information for review, medical necessity of the requested treatment has not been established. The Requested Treatment: Extracorporeal shockwave therapy left hand/wrist times 3 is not medically necessary and appropriate.

Electromyography (EMG) and nerve conduction velocity (NCV) of the upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter--Electrodiagnostic testing (EMG/NCS).

Decision rationale: The California MTUS/ACOEM Guidelines state, "Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks." The ODG regarding nerve conduction studies (NCS) states, "Not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. EMGs (electromyography) are recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious." The injured worker's diagnoses include sprain/strain of left hand/wrist with extensor tendinitis, crush injury of left hand/wrist with residual loss of grip strength of left hand, and left upper extremity peripheral nerve entrapment. Injured worker is already diagnosed with moderate carpal tunnel syndrome bilaterally from previous EMG/NCV studies. There is insufficient information provided by the attending health care provider to establish the medical necessity or rationale for the repeat request of electrodiagnostic studies. The request for Electromyography (EMG) and nerve conduction velocity (NCV) of the upper extremity is not medically necessary and appropriate.

Interferential (IF) unit for a 30 day trial: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-119. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg (Acute & Chronic) Interferential current therapy (IFC).

Decision rationale: Interferential Current Stimulation (ICS) is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and/or methodologic issues. In addition although proposed for treatment in general for soft tissue injury or for enhancing wound or fracture healing, there is insufficient literature to support Interferential current stimulation for treatment of these conditions. There are no standardized protocols for the use of interferential therapy; and the therapy may vary according to the frequency of stimulation, the pulse duration, treatment time, and electrode-placement technique. As per Official Disability Guidelines (ODG): Interferential current therapy (IFC) is under study for osteoarthritis and recovery post knee surgery. Not recommended for chronic pain or low back problems. After knee surgery, home interferential current therapy (IFC) may help reduce pain, pain medication taken, and swelling while increasing range of motion, resulting in quicker return to activities of daily living and athletic activities. The injured worker's diagnoses include sprain/strain of left hand/wrist with extensor tendinitis, crush injury of left hand/wrist with residual loss of grip strength of left hand, and left upper extremity peripheral nerve entrapment. The treating provider's notes do not provide clear information about the failure of current conservative treatment measures. Based on the currently available information in the submitted Medical Records of this injured worker, and per review of the guidelines, the medical necessity for Interferential Current Stimulation (ICS) unit has not been established. The requested Treatment for Interferential Current Stimulation (ICS) is not medically necessary.

Hot/cold therapy home use purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter--Cold/heat packs.

Decision rationale: ODG recommends Ice massage compared to control had a statistically beneficial effect on ROM, function and knee strength. Cold packs decreased swelling. Hot packs had no beneficial effect on edema compared with placebo or cold application. Ice packs

did not affect pain significantly compared to control in patients with knee osteoarthritis. ODG states Continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. This meta-analysis showed that cryotherapy has a statistically significant benefit in postoperative pain control, while no improvement in postoperative range of motion or drainage was found. As the cryotherapy apparatus is fairly inexpensive, easy to use, has a high level of patient satisfaction, and is rarely associated with adverse events, we believe that cryotherapy is justified in the postoperative management of surgery. Although the use of equipment is appropriate post-operatively, the medical records neither indicate that this injured worker had any recent surgery nor, is scheduled to have one. As such, there is no indication for use of cold unit at this time. For heat therapy special equipment is not needed. ODG also state mechanical circulating units with pumps have not been proven to be more effective than passive hot and cold therapy. The requested treatment: purchase of Cold/Heat therapy unit is not medically necessary and appropriate.

X-ray for left hand/wrist: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

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 Chapter-Radiography.

Decision rationale: As per Official Disability Guidelines (ODG), Radiography is recommended for most patients with known or suspected trauma of the hand, wrist, or both, the conventional radiographic survey provides adequate diagnostic information and guidance to the surgeon. However, in one large study, wrist fractures, especially those of the distal radius and scaphoid, accounted for more delayed diagnoses than any other traumatized region in patients with initial normal emergency room radiographs. The injured worker's diagnoses include sprain/strain of left hand/wrist with extensor tendinitis, crush injury of left hand/wrist with residual loss of grip strength of left hand, and left upper extremity peripheral nerve entrapment. From the submitted Medical Records it is unclear how the X-ray will change the management. The injured worker has no progressive neurological deficits, no new red flags, and no recent acute injury. Without such evidence and based on guidelines cited, the request for X-ray left hand/wrist is not medically necessary and appropriate.

Functional capacity evaluation (FCE): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-90. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter-Work conditioning, work hardening.

Decision rationale: A number of functional assessment tools are available, including functional capacity exams and videotapes. Most assess general functioning, but modifications to test work-related functioning are under development or can be created by the clinician. ODG states valid Functional Capacity Evaluation (FCE) should be performed, administered and interpreted by a licensed medical professional. The results should indicate consistency with maximal effort, and demonstrate capacities below an employer verified physical demands analysis (PDA). Inconsistencies and/or indication that the patient has performed below maximal effort should be addressed prior to treatment in these programs. Within the medical information available for review, the injured worker has chronic pain and there is no indication the injured worker is close or at maximum-medical-improvement (MMI). There is no documentation of prior unsuccessful return-to-work (RTW) attempts. Medical records lack information about job description, physical demand level and specific work-related tasks. Also records do not document injured worker's return to work goals. The medical necessity of the requested service has not been established and therefore is not medically necessary.

Acupuncture left hand/wrist 2 times per week for 4 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: This prescription for acupuncture is evaluated in light of the MTUS recommendations for acupuncture. The MTUS recommends an initial trial of 3-6 visits of acupuncture. Per the MTUS, "acupuncture is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery". Medical necessity for any further acupuncture is considered in light of "functional improvement". The records are not clear if the injured worker had prior acupuncture therapy, and what was the objective outcome. There was no discussion by the treating physician regarding a decrease or intolerance to pain medications. Also eight visits of acupuncture exceed the MTUS recommendation. Given the MTUS recommendations for use of acupuncture, the requested treatment Acupuncture left hand/wrist 2 times per week for 4 weeks is not medically necessary and appropriate.

MRI for left hand/wrist: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

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, & Hand Chapter-MRI's (magnetic resonance imaging).

Decision rationale: California MTUS states imaging studies to clarify the diagnosis may be warranted if the medical history and physical examination suggest specific disorders. Official Disability Guidelines (ODG) state that indications for MRI of the wrist are acute hand or wrist trauma, suspect acute scaphoid fracture, radiographs normal, next procedure if

immediate confirmation or exclusion of fracture is required, acute hand or wrist trauma, suspect gamekeeper injury (thumb MCP ulnar collateral ligament injury), chronic wrist pain, plain films normal, suspect soft tissue tumor, chronic wrist pain, plain film normal or equivocal, suspect Kienbock's disease. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. The injured worker's diagnoses include sprain/strain of left hand/wrist with extensor tendinitis, crush injury of left hand/wrist with residual loss of grip strength of left hand, and left upper extremity peripheral nerve entrapment. There is no evidence of suspected fracture, no recent injury and no red flags. Based on submitted information, the requested treatment MRI of Left hand/wrist cannot be determined as medically necessary and appropriate therefore is not medically necessary.

Overnight sleep study: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain, Polysomnography.

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

Decision rationale: Official Disability Guidelines (ODG) Polysomnograms / sleep studies are recommended for the combination of indications listed below: Excessive daytime somnolence; Cataplexy (muscular weakness usually brought on by excitement or emotion, virtually unique to narcolepsy); Morning headache (other causes have been ruled out); Intellectual deterioration (sudden, without suspicion of organic dementia); Personality change (not secondary to medication, cerebral mass or known psychiatric problems); Sleep-related breathing disorder or periodic limb movement disorder is suspected; 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; Unattended (unsupervised) home sleep studies for adult patients are appropriate with a home sleep study device with a minimum of 4 recording channels (including oxygen saturation, respiratory movement, airflow, and EKG or heart rate). Within the submitted records there is mention of injured worker complaining of insomnia due to chronic pain. There is no mention of any concerns that meet the guidelines for sleep studies. It is not clear if the injured worker had any prior unattended (unsupervised) home sleep studies. In the absence of such information, the request for Overnight sleep study is not medically necessary and appropriate.