

Case Number:	CM15-0092768		
Date Assigned:	05/19/2015	Date of Injury:	01/15/2015
Decision Date:	10/08/2015	UR Denial Date:	04/17/2015
Priority:	Standard	Application Received:	05/13/2015

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:

The injured worker is a 26-year-old female, who sustained an industrial injury on 1/15/15. The injured worker has complaints of left wrist and thumb pain with numbness and tingling. The documentation noted that the carpometacarpal joint of the left thumb is tender. The diagnoses have included tenosynovitis; medial neuropathy, wrist, carpal tunnel syndrome and carpal tunnel syndrome. Treatment to date has included acetaminophen and etodolac extended release. The request was for anaprox 550mg #60; magnetic resonance imaging (MRI) of the right wrist; electromyography/nerve conduction velocity study of the right and left upper extremity and Functional Restoration Program two times week times three weeks, right wrist (6 sessions).

IMR ISSUES, DECISIONS AND RATIONALES

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

Anaprox 550mg #60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-68, 73.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (Non-steroidal anti-inflammatory drugs) Page(s): 67.

Decision rationale: Anaprox or Naproxen is an NSAID. As per MTUS Chronic pain guidelines, NSAIDs are useful of osteoarthritis related pain. Due to side effects and risks of adverse reactions, MTUS recommends as low dose and short course as possible. Documentation documents improvement in pain and improvement in function on this medication as part of a medication regiment. Pt appears to have been using naproxen for several months. However, chronic use of naproxen has significant side effects including increased risk for heart attacks and strokes. Chronic use is not recommended. Anaprox is medically necessary.

MRI of the right wrist: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): Table 11-7.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 259, 268-269.

Decision rationale: As per ACOEM guidelines, indications for wrist imaging include red flag findings, physiological evidence of neurological or physiological dysfunction, failure to progress in strengthening program and pre-invasive procedure. Patient has shown improvement with physical therapy. The documentation does not support any indication for imaging. The requesting chiropractor has not documented any worsening symptoms or rationale for request. The neurological exam is benign. Patient already has prior X-rays that were benign but no official report was provided for review. MRI is most useful in detecting infections and arthritis of the wrist which is not the diagnoses being considered by provider. The provider has failed to provide a rational evidence based reason for requesting unnecessary studies. MRI of wrist 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): Table 11-6.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 272.

Decision rationale: As per ACOEM Guidelines, Nerve Conduction Velocity Studies is not recommended for repeat routine evaluation of patients for nerve entrapment. It is recommended in cases where there is signs of median or ulnar nerve entrapment with failure of conservative care. Exam is consistent with carpal tunnel syndrome. However, documentation shows improvement in pain and function with some residual paresthesias. Exam shows no sensory or motor deficits. There is no rationale documented as to why NCV needs to be done with clinically improving CPS and how it will change management. NCV is not medically necessary.

EMG of the left upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): Table 11-6.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182.

Decision rationale: As per ACOEM Guidelines, EMG is not recommended if prior testing, history and exam is consistent with nerve root dysfunction. EMG is recommended if pre procedure or surgery is being considered. Pt has documented improvement in symptoms. There is no exam or signs consistent with radiculopathy. There is no rationale about why this test was requested. EMG is not medically necessary.

NCV of the left upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): Table 11-6.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 272.

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Functional restoration program 2 x week x 3 weeks, right wrist (6 sessions): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Programs Page(s): 31-32.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Programs (functional restoration programs) Page(s): 30-32.

Decision rationale: As per MTUS Chronic pain guidelines certain criteria should be met before recommendation to a program. It requires: 1) A functional baseline testing to measure baseline improvement. Fails criteria. 2) Failure of prior chronic pain treatment. Fails criteria. Patient has only minimal conservative care attempted with only 4 physical therapy sessions noted. 3) Loss of function due to pain. This was not appropriately documented. Fails criteria. 4) Not a candidate for surgery. No explanation documented as to why patient is not a surgical candidate. Fails criteria. 5) Motivation to change. Nothing documented. Fails criteria. 6) Negative predictors for success has been addressed. Nothing documented. Fails criteria. Patient has yet to fail conservative therapy and is in the early phase of conservative care. Patient does not meet a single indication for FRP. Functional Restoration Program is not medically necessary.