

Case Number:	CM13-0015933		
Date Assigned:	10/11/2013	Date of Injury:	09/18/2012
Decision Date:	01/16/2014	UR Denial Date:	08/12/2013
Priority:	Standard	Application Received:	08/23/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine, and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 53 year old female whose original date of injury is 9/18/12. The mechanism of injury was a bar spring knocking the patient's hand back against a cement vault. The patient initially complained of pain in the neck and left shoulder with radiation to the arms, wrists, and hands. She has a working diagnosis of cervicgia, shoulder impingement, and low back pain. The physical examination on 7/17/13 indicates that cervical spine range of motion to forward flexion is 60°, extension is to 25°, and rotation is 30° bilaterally. There is tenderness to palpation over the bilateral cervical paraspinal muscles, but no spinous process tenderness or masses palpable along the cervical spine. There was negative Spurling's maneuver bilaterally. Motor strength testing reveals 5/5 symmetric strength in the bilateral upper extremities except for 4+/5 on left grip strength and left thumb extension. Sensory examination is grossly intact to light touch in pinprick throughout the upper extremities, except in the left median nerve distribution. Reflexes are symmetric at 1+/4 in the bilateral upper extremities. Negative Hoffman's sign and negative Babinski sign are noted.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 271-273, 561-563, Chronic Pain Treatment Guidelines Page(s): 68-69, 73. Decision based on Non-MTUS

Citation Official Disability Guidelines for Carpal Tunnel Syndrome, and for the Forearm, Wrist, and Hand

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 177-178, 271-273.

Decision rationale: Chapter 8 of the ACOEM (Neck and Upper Back Complaints) contains the following discussion of electrodiagnostic testing: "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." The ACOEM Guidelines on pages 271-273 includes Table 11-7 entitled "Summary of Recommendations and Evidence." With regard to detection of neurologic abnormalities, there is a recommendation of nerve conduction studies for median (B) or ulnar (C) impingement at the wrist after failure of conservative treatment. There is recommendation against "routine use of NCV or EMG in diagnostic evaluation of nerve entrapment or screening in patients without symptoms (D)." In the case of this injured worker, there is documentation of suspicion for carpal tunnel syndrome. The ACOEM guidelines recommend nerve conduction studies for median impingement at the wrist after failure of conservative treatment, but there is no indication for electromyography at this time. "Other peripheral nerve entrapment" is on the differential diagnosis as stated by the requesting healthcare provider, but peripheral nerve entrapments are not evaluated by electromyography. There is no documentation of any suspicion for myopathy or other neurologic process for which electromyography is warranted. This request is recommended for non-certification.

NCS bilateral upper extremities: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 271-273, 561-563, Chronic Pain Treatment Guidelines Page(s): 68-69, 73. Decision based on Non-MTUS Citation Official Disability Guidelines for Carpal Tunnel Syndrome, and for the Forearm, Wrist, and Hand

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