Case Number:	CM14-0172989		
Date Assigned:	10/23/2014	**Date of Injury:**	07/03/2014
Decision Date:	12/02/2014	**UR Denial Date:**	10/06/2014
Priority:	Standard	**Application Received:**	10/20/2014

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. The expert reviewer is Board Certified in General Preventive Medicine, has a subspecialty in Occupational and Environmental Medicine, and is licensed to practice in Iowa. 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/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:

This patient is a 31-year-old employee with date of injury of 07/03/2014. Subjective complaints include pain 5-6/10, most severe in the cervical spine, left shoulder pain, lumbar spine pain. He has frequent, moderate to severe pain in the low back occasionally radiating to the left groin and anterior medial left thigh to the knee. Objective findings include palpable tenderness at the left upper trapezius and paravertebral muscles, deep tendon reflexes, sensory and motor power testing in the upper extremities were normal. Palpable tenderness at the left acromioclavicular joint left biceps tendon groove, supraspinatus deltoid complex and rotator cuff. Impingement test was positive on the left. Palpable tenderness at the left lumbar paravertebral muscles, spinous processes and bilateral sacroiliac joints, tiptoe walking reproduced pain in the left groin and left thigh, decreased cervical flexion at 49 degrees, extension at 32 degrees, left lateral bending at 28 degrees, right lateral bending at 23 degrees, and left and right rotation at 22 degrees. There was decreased thoracolumbar flexion at 31 degrees, left lateral bending at 17 degrees, right lateral bending at 24 degrees, left rotation at 8 degrees, and right rotation at 13 degrees. Decreased left shoulder flexion at 94 degrees, abduction at 121 degrees, internal rotation at 37 degrees, and external rotation at 58 degrees. Treatment is unknown. The utilization review determination was rendered on 10/06/2014 recommending non-certification of Voltage-Actuated Sensory Nerve Conduction Threshold (VSNCT).

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltage-Actuated Sensory Nerve Conduction Threshold (VSNCT): 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)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260-262 165-194. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Electrodiagnostic Testing (EMG/NCS)

Decision rationale: ACOEM States "Appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include Nerve Conduction Studies (NCS), or in more difficult cases, Electromyography (EMG) may be helpful." ODG states "Recommended needle EMG or NCS, depending on indications. Surface EMG is not recommended. Electromyography (EMG) and Nerve Conduction Studies (NCS) are generally accepted, well-established and widely used for localizing the source of the neurological symptoms and establishing the diagnosis of focal nerve entrapments, such as carpal tunnel syndrome or radiculopathy, which may contribute to or coexist with CRPS II (causalgia), when testing is performed by appropriately trained neurologists or physical medicine and rehabilitation physicians (improperly performed testing by other providers often gives inconclusive results). As CRPS II occurs after partial injury to a nerve, the diagnosis of the initial nerve injury can be made by electrodiagnostic studies." ODG further clarifies "NCS is not recommended, but EMG is 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 treating physician does not document evidence of radiculopathy, muscle atrophy, and abnormal neurologic finings. The treating physician has not met the above ACOEM and ODG criteria for an NCV of the upper extremities. As such, the request for Voltage-Actuated Sensory Nerve Conduction Threshold (VSNCT) is not medically necessary.