

Case Number:	CM14-0023989		
Date Assigned:	06/11/2014	Date of Injury:	07/01/2011
Decision Date:	07/15/2014	UR Denial Date:	02/13/2014
Priority:	Standard	Application Received:	02/25/2014

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 Internal 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 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:

The patient is a 60 year old female who was injured on 07/11/2011. She sustained an injury to her left ring finger from a staple wire while pulling a chart from a file cabinet. Prior medication history included Norco 325, Anaprox 550, Prilosec 20 mg, Fexmid 7.5 mg. Prior treatment history has included cervical nerve block. Diagnostic studies reviewed include MRI of the left elbow dated 02/14/2012 revealed a small joint effusion with degenerative changes. Pain Management report dated 01/13/2014 reports the patient complained of ongoing debilitating pain in her left upper extremity with hypersensitivity and swelling in her left forearm and hand. She reported marked weakness in her left hand and would occasionally drop things. On exam, there is tenderness to palpation over the posterior cervical musculature bilaterally with increased muscle rigidity. Cervical range of motion is decreased in all planes. There was marked atrophy of the left thenar and hypothenar muscles. Deep tendon reflexes were 2/4 bilaterally. There was diffused left upper extremity hypoalgesia with discoloration. Shoulder range of motion on the left shoulder revealed 120 degrees of flexion and 40 degrees of extension. The patient was diagnosed with complex regional pain syndrome of the left upper extremity, status post laceration of the left ring finger with resultant in infection, squamous cell carcinoma of the left ring finger, status post skin graft from antecubital fossa to the left ring finger and cervical spine sprain/strain. The treatment and plan included a request for an EMG/NCV of the bilateral upper extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

ELECTROMYOGRAPHY /NERVE CONDUCTION VELOCITY STUDIES OF THE BILATERAL UPPER EXTREMITIES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

Decision rationale: The CA MTUS guidelines recommend EMG/Nerve Conduction Studies as an option to identify subtle focal neurologic dysfunction in patients with neck/arm symptoms, or both, which persists for greater than 3-4 weeks. The patient has had left arm weakness and findings concerning for neuropathy. However, it is unclear if the symptoms have progressed or improved most recently with conservative therapy. Additionally, it is unclear why a request is made for bilateral extremities when the documents solely discuss left sided complaints and findings. Based on the guidelines and criteria as well as the clinical documentation stated above, the request is not medically necessary.