

Case Number:	CM14-0036222		
Date Assigned:	06/25/2014	Date of Injury:	05/25/2012
Decision Date:	07/22/2014	UR Denial Date:	02/27/2014
Priority:	Standard	Application Received:	03/25/2014

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 Physical Medicine and Rehabilitation 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 injured worker is a 65-year-old female with a reported date of injury on 05/25/2012. The injury reportedly occurred when the injured worker was struck by a client from behind when the injured worker entered the restroom. Her previous treatments were noted to include medications and physical therapy. Her diagnoses were noted to include depression with emotional distress, cervicogenic/tension headaches, dizziness, comorbid arthritic condition involving the neck/right scapular and right shoulder areas and with associated right upper extremity symptoms with possible cervical radiculopathy, sleep initiation and maintenance insomnia secondary to pain and with associated daytime impairment. An electromyography and nerve conduction study was performed 03/10/2014 which showed abnormal electrodiagnostic studies of the cervical spine and upper extremities showed electrical evidence of carpal tunnel syndrome, moderate, bilateral, and no evidence of cervical radiculopathy or any other peripheral nerve compression.. The progress note dated 05/02/2014 noted the injured worker complained of pain and moodiness. The progress note dated 04/22/2014 reported complaints of emotional distress causing the injured worker to feel depressed and she was worried about her work limitations and physical limitations. The injured worker complained of headaches which were present since the date of injury and the pain began in the neck and spread to the occipital area bilaterally and forward to the temporoparietal areas bilaterally. The injured worker complained of dizziness, weakness, and also double vision at times when she was having the headaches. The injured worker was not able to do her chores and the pain medicine does help to relieve the pain and the injured worker noted she had minor, and frequent headaches, before the work injury but they were not similar to the current headaches. The injured worker also complained of difficulty sleeping due to awakening repeatedly due to pain. The physical examination reported headaches, localized muscle weakness, numbness and tingling to the arms, joint pain, back pain, neck pain, arm pain, and

wrist pain. The provider reported the injured worker could elevate her trapezius muscles bilaterally equally, but did have pain to the right side. The injured worker was able to abduct the right shoulder to only about 90 degrees because of pain. Motor strength to the extremities was shown to be 5/5. Deep tendon reflexes to the bilateral upper extremities were shown 2+ at the biceps and triceps/brachial radialis was 1+. Muscle sound to the lower extremities was 5/5 and deep tendon reflexes were 1+. The sensory examination was intact throughout the upper and lower extremities and also involving all fingers of both hands. The Request for Authorization was not submitted within the medical records. The request is for electromyography and nerve conduction velocity to the right upper extremity; however, the provider's rationale was not submitted within the medical records.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electromyography (EMG) Right Upper Extremity: Upheld

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

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

Decision rationale: The injured worker has had a previous electromyography to the bilateral upper extremities in 03/2014. According to the CA MTUS/ACOEM Guidelines, patients with true hand and wrist problems, initial studies are not needed until after a 4 to 6 week period of conservative care and observation. Most patients improve quickly, provided red flag conditions are ruled out. In cases of peripheral nerve impingement, if no improvement or worsening has occurred within 4 to 6 weeks, electrical studies may be indicated. The primary care physician may refer for a local lidocaine injection with or without corticosteroids. The electromyography is used to identify and define forearm, wrist, and hand pathology such as carpal tunnel syndrome. The injured worker had a previous electromyography to the bilateral upper extremities which did result in carpal tunnel syndrome diagnosis. Due to the previous electromyography it is not warranted for a repeat electromyography at this time. The request for an electromyography to the right upper extremity is non-certified.

Nerve conduction velocity (NCV) Right Upper Extremity: Upheld

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

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

Decision rationale: The injured worker has had a previous nerve conduction velocity to the bilateral upper extremities in 03/2014. According to the CA MTUS/ACOEM Guidelines, patients with true hand and wrist problems, initial studies are not needed until after a 4 to 6 week

period of conservative care and observation. Most patients improve quickly, provided red flag conditions are ruled out. In cases of peripheral nerve impingement, if no improvement or worsening has occurred within 4 to 6 weeks, electrical studies may be indicated. The primary care physician may refer for a local lidocaine injection with or without corticosteroids. The electromyography is used to identify and define forearm, wrist, and hand pathology such as carpal tunnel syndrome. The injured worker had a previous nerve conduction velocity to the bilateral upper extremities which did result in carpal tunnel syndrome diagnosis. Due to the previous nerve conduction velocity it is not warranted for a repeat nerve conduction velocity at this time. The request for an nerve conduction velocity to the right upper extremity is non-certified.