

<b>Case Number:</b>	CM14-0201454		
<b>Date Assigned:</b>	12/11/2014	<b>Date of Injury:</b>	11/18/2002
<b>Decision Date:</b>	01/28/2015	<b>UR Denial Date:</b>	11/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/01/2014

### 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 Emergency 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:

Patient with reported date of injury on 11/18/2002. Patient has a diagnosis of post R hand laceration with tendon injury, R chronic tendon injury post reconstruction, R ulnar neuritis, R medial neuritis, post R carpal tunnel release-wrist flexor tenosynovectomy(1/8/04), post R release of first dorsal compartment, second tunnel release and tenosynovectomy(9/19/07), L carpal tunnel syndrome, L ulnar neuropathy cubital tunnel, post L carpal tunnel release-wrist tenosynovectomy(2/25/13), depression/anxiety and R recurrent de Quervain's disease post release and injections. Medical reports reviewed. Last report available until 11/7/14. Patient complains of R wrist pain, weakness in both hands, numbness and tingling in both arms. Depression and anxiety. Difficulty sleeping. Objective exam reveals positive medial nerve compression test, Tinel's sign, Phalen's sign positive on R side. Decreased light touch median nerve more than ulnar on R side. Positive Finkelstein's test on right 1st dorsal compartment. Functional Capacity Evaluation was requested to "identify any work limitation". EMG/NCV was requested for "increasing signs" to allow for comparison. Prior imaging or Electrodiagnostic reports were not provided for review. Current medications include Tramadol, Omeprazole, Ambien and Cyclobenzaprine. Independent Medical Review is for Functional Capacity Evaluation, EMG/NCV of bilateral upper extremity including SSEP and Zolpidem 10mg #30 with 1 refill. Prior UR on 11/4/14 recommended non-certification.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Functional capacity evaluation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines -- Fitness For Duty

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 81.

**Decision rationale:** As per ACOEM guidelines, determining limitations of work "is not really a medical issue" and that most assessing physicians should be able to determine limitations without additional complex testing modalities. As per ACOEM Chapter 1 Prevention, pg 12; "there is no good evidence that functional capacity evaluations are correlated with a lower frequency of health complaints and injuries." While there may be occasional need for FCE, the treating physician has not documented why any work limitation assessment could not be done without a full FCE. The request for FCE is not medically necessary.

**EMG / NCV of the bilateral upper extremities including SSEP:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 10 Elbow Disorders (Revised 2007), Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 178, 33, 261. Decision based on Non-MTUS Citation Official Disability Guidelines, Elbow (Acute & Chronic) / Carpal Tunnel Syndrome (Acute & Chronic)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 272,182.

**Decision rationale:** EMG and NCV requested by provider are 2 different tests, testing for different pathologies. If one test is not recommended, this requested will be considered not medically necessary as per MTUS independent medical review guidelines. 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. There is documentation of decreased sensation and weakness that correlates with known median or ulnar nerve entrapment but symptoms are chronic and unchanged from prior. NCV is not medically necessary. 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 not had any documented changes in neurological exam or complaints. There is no exam or signs consistent with radiculopathy There is no rationale about why testing is requested for a chronic condition. EMG is not medically necessary. EMG and NCV of bilateral upper extremities are not medically necessary.

**Zolpidem 10mg #30 with 1 refill:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) <Pain(Chronic)>, <Insomnia Treatment>.

**Decision rationale:** There is no specific sections in the MTUS chronic pain or ACOEM guidelines that relate to this topic. Ambien is a benzodiazepine agonist approved for insomnia. As per ODG guidelines, it recommends treatment of underlying cause of sleep disturbance and recommend short course of treatment. Patient has been on Ambien chronically. There is no documentation of other conservative attempts at treatment of sleep disturbance or sleep studies. The chronic use of Ambien is not medically appropriate and is not medically necessary.