

Case Number:	CM15-0105450		
Date Assigned:	06/09/2015	Date of Injury:	11/21/2012
Decision Date:	07/21/2015	UR Denial Date:	05/21/2015
Priority:	Standard	Application Received:	06/01/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Arizona, California
 Certification(s)/Specialty: Family Practice

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 (IW) is a 39-year-old male who sustained an industrial injury on 11/21/2012. Diagnoses include rule out right wrist TFCC tear/tendinopathy and rule out early sympathetically maintained pain syndrome, right upper extremity. Treatment to date has included medications, wrist surgery, activity modification, physical and occupational therapy and home exercise. According to the progress notes dated 4/23/15, the IW reported right hand and wrist pain rated 5/10. He complained of this area being "overly sensitive" and was concerned about related activity intolerance. On examination, hyperalgesia and hyperesthesia was noted from 5 cm proximal to the wrist, distally. Jamar handgrip was measured at 5, 10, 5 on the right and 20, 25, and 20 on the left. Distal pulses were intact and symmetrical, but the right upper extremity temperature was slightly decreased compared to the left. Medications were hydrocodone 10 mg twice daily, Tramadol ER, Naproxen and Pantoprazole. A request was made for electromyography/nerve conduction velocity studies (EMG/NCVS) of the bilateral upper extremities to rule out early sympathetically maintained pain syndrome.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV Bilateral Upper Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 177-179.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 268. Decision based on Non-MTUS Citation ODG - neck guidelines and pg 28.

Decision rationale: According to the guidelines, an EMG is recommended to clarify nerve root dysfunction in cases of suspected disk herniation preoperatively or before epidural injection. It is not recommended for the diagnoses of nerve root involvement if history and physical exam, and imaging are consistent. An NCV is not recommended to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but recommended if the EMG is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely based on the clinical exam. In this case, the EMG may be necessary to determine nerve root dysfunction due to worsening symptoms and hypoesthesias. The need for an NCV cannot be determined unless the EMG is performed. The request for an EMG and NCV is not necessary simultaneously and therefore not medically necessary.