MAXIMUS Federal Services

Case Number:	CM15-0109333		
Date Assigned:	06/15/2015	Date of Injury:	07/16/2008
Decision Date:	07/22/2015	UR Denial Date:	05/19/2015
Priority:	Standard	Application Received:	06/05/2015

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: Pennsylvania, Ohio, California
Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 54 year old female, who sustained an industrial injury on 07/16/2008. According to a progress report dated 03/30/2015, the injured worker was referred for headaches and dizziness. She complained of a grinding sound with neck rotation. She was concerned regarding bumps that had appeared under the skin in the anterolateral neck. She described constant slight to moderate posterior midline neck pain. She also reported that she had rapid onset of bilateral hand numbness with any gripping/grasping activity. Assessments included neck pain, hand pain, carpal tunnel syndrome and ulnar neuropathy at elbow. Physical examination demonstrated limited cervical passive range of motion in all directions with guarding. There was diffuse tenderness to palpation of cervical paraspinals, focal tenderness of right greater occipital nerve and left greater occipital nerve. Bilateral foraminal compression tests and Lhermitte's sign were negative. She had very poor effort with all upper extremity motor testing. Normal tone and bulk were present. There was no definite organic weakness present. No hemiparesis was present. There was no rigidity or bradykinesia and no spasticity present. Light touch and pinprick were intact in all extremities. Sensation was intact to pinprick in all upper extremity dermatomes. Mild postural and action tremor of the bilateral upper extremity was noted. No unilateral appendicular ataxia was noted. Antalgic gait was noted. 1-2+ symmetric reflexes were present in the upper extremities. Tinel's sign was negative over the bilateral anterior wrists and bilateral ulnar grove. She complained of increased skin sensitivity over above locations. The treatment plan included a course of cervical physical therapy for persistent neck stiffness and spasm, continuation with pain management provider, bilateral upper extremity EMG/NCV to evaluate for recurrent carpal tunnel syndrome versus other mononeuropathies versus cervical radiculopathy. The injured worker was status post carpal tunnel release and ulnar

nerve transpositions with persistent unexplained intermittent numbness. The provider noted that that a cervical MRI would be needed to evaluate for spinal cord compression if electrodiagnostic tests were unrevealing. According to a pain management progress report dated 05/19/2015, the injured worker complained of neck pain that radiated down to both her shoulders all the way down her arms to her fingers. She reported numbness and tingling in her hands. Medication regimen included Butrans patch, Gabapentin, Norco and Tramadol. Objective findings included decreased right hand grip strength, allodynia to light touch at the right lateral thumb, positive Tinel's sign on the left, positive pain with cervical right and left lateral bending, palpable spasm over the bilateral cervical paraspinous muscle with positive twitch response, positive palpable spasms over the right trapezius with positive twitch response, tenderness to palpation at bilateral lateral epicondyle and decreased range of motion with left shoulder flexion and abduction to pain. Diagnoses included cervical sprain, right shoulder impingement syndrome and carpal tunnel syndrome. Right hand injections in the past provided minimal relief. The provider noted that she had shown functional improvement with activities of daily living and had returned to work. Medications were continued. Currently under review is the request for one electromyography and nerve conduction velocity studies 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:

One Electromyography and 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. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment for Workers' Compensation, online edition, Chapter: Neck & Upper Back (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

Decision rationale: MTUS/ACOEM recommend electrodiagnostic studies of the cervical spine/upper extremities to evaluate specific neurological symptoms/findings which suggest a neurological differential diagnosis. The rationale or differential diagnosis for the currently requested electrodiagnostic study are not apparent; the patient is status post bilateral carpal tunnel releases without an alternate proposed differential diagnosis for this study.. This requested repeat study is not medically necessary.