

Case Number:	CM15-0137744		
Date Assigned:	07/27/2015	Date of Injury:	02/01/2010
Decision Date:	08/28/2015	UR Denial Date:	07/09/2015
Priority:	Standard	Application Received:	07/16/2015

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: Texas, New York, California
 Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 applicant is a represented [REDACTED] employee who has filed a claim for chronic low back, wrist, neck and shoulder pain reportedly associated with an industrial injury of February 1, 2010. In a Utilization Review report dated July 9, 2015, the claims administrator failed to approve a request for bilateral upper extremity electrodiagnostic testing. An RFA form on July 1, 2015 and an associated progress note of June 9, 2015 were cited in the decision, although these were not seemingly discussed or summarized. On June 9, 2015, the applicant reported ongoing complaints of neck pain with radiation of pain to the upper extremities. Ancillary complaints of headaches, low back pain, wrist pain, shoulder pain, and hip pain were reported. Bilateral upper and lower extremity electrodiagnostic testing was sought. The attending provider noted that the applicant had undergone earlier cervical fusion surgery at C4 through C7 and had also undergone left and right carpal tunnel release surgeries. The applicant was asked to return to work. It was stated that the applicant was considering a lumbar epidural steroid injection. Unspecified medications were refilled under separate cover. The attending provider also alluded to historical electrodiagnostic testing of July 10, 2012 which was notable for moderate bilateral carpal tunnel syndrome.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral Upper Extremity EMG/NCV: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 272; 261; 182.

Decision rationale: No, the request for electrodiagnostic testing of the bilateral upper extremities was not medically necessary, medically appropriate, or indicated here. As noted in the MTUS Guideline in ACOEM Chapter 11, Table 11-7, page 272, the routine usage of EMG-NCV testing and evaluation of nerve entrapment is deemed "not recommended." Here, the fact that electrodiagnostic testing of bilateral upper and bilateral lower extremities were concurrently ordered strongly suggested that the attending provider was, in fact, ordering said studies for routine evaluation purposes, without any clearly formed intention of acting on the results of the same. The MTUS Guideline in ACOEM Chapter 8, Table 8-8, page 182 also notes that EMG testing for diagnosis of [cervical] nerve root involvement is deemed "not recommended." Findings of history, physical exam, and imaging study are consistent. Here, the applicant had undergone multilevel cervical fusion surgery. The applicant, thus, already carried a diagnosis of clinically-evident, radiographically confirmed cervical radiculopathy, seemingly obviating the need for the electrodiagnostic testing in question. In the similar vein, while the MTUS Guideline in ACOEM Chapter 11, page 261 does acknowledge that electrodiagnostic testing may be repeated later in the course of treatment if symptoms persist in individuals in whom earlier testing was negative. Here, however, historical electrodiagnostic testing of 2012 positive for moderate bilateral carpal tunnel syndrome seemingly obviated the need for repeat testing. Again, the treating provider did not state how the proposed electrodiagnostic testing would influence or alter the treatment plan. There was no mention of the applicant's considering or contemplating further cervical spine surgery, a cervical epidural steroid injection, or repeat carpal tunnel release surgery based on the same. Therefore, the request was not medically necessary.