

Case Number:	CM15-0161781		
Date Assigned:	08/28/2015	Date of Injury:	09/26/2002
Decision Date:	10/02/2015	UR Denial Date:	08/03/2015
Priority:	Standard	Application Received:	08/18/2015

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: 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 60 year old male with an industrial injury dated 09-26-2002. The mechanism of injury is documented as a motor vehicle accident. His diagnosis included status post left carpal tunnel release, status post left dorsal wrist ganglion cyst excision, left ulnar neuritis, left de Quervain's disease, left median neuritis, left basal joint degenerative traumatic arthritis and right de Quervain's disease. Prior treatment included surgery to left wrist, post op therapy, medications and diagnostics. Comorbid conditions included congestive heart failure and high blood pressure. He presented on 06-30-2015 with complaints of severe pain in the left hand, fingers, wrist and elbow with occasional pain in the neck and back. Physical exam noted pain on palpation of the ulnar nerve and lateral epicondyle. Elbow flexion test and Tinel's sign were positive on the left. Light touch sensation was decreased on the left with median greater than ulna. The provider documents "currently he is performing his regular work duties with difficulties."The treatment requests are: Somatosensory Evoked Potentials of the Ulnar and Median Nerves qty 1.00; NCS (nerve conduction studies) of the right upper extremity (including SSEP for Ulnar and median nerves); EMG (Electromyogram) of the right upper extremity (including SSEP for Ulnar and median nerves);

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG (Electromyogram) of the right upper extremity (including SSEP for Ulnar and median nerves): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints Page(s): 260-262, 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and upper Back chapter, under Somatosensory Evoked Potentials.

Decision rationale: The patient presents with severe pain in the left hand/fingers, wrist and elbow. Sharp radiating pain from the left elbow to the hand/fingers. Occasional pain in the neck. The request is for EMG (electromyogram) of the right upper extremity (including SSEP for ulnar and median nerves). The request for authorization is dated 07/10/15. The patient is status post left carpal tunnel release, 2007. Status post left dorsal wrist ganglion cyst excision, 2007. EMG/NCS of the bilateral upper extremities, 02/10/09, shows Normal EMG; Abnormal NCS - left mild compression of the median nerve at the carpal tunnel versus normal electrodiagnostic changes after CTS surgery by electrodiagnostic criteria. Physical examination of the elbows and forearms reveal pain on palpation to the left ulnar nerve and left lateral epicondyle and mobile wad. Positive subluxation: cubital tunnel, elbow flexion test, and Tinel's sign on the left. Positive Finkelstein test, direct palp-1st dorsal comp, bilaterally. Direct palpation: scaphoid & lunate positive on left. L-Tq compression test and palpation positive on left. Grind test & CMC-1 stress load positive bilaterally. Reduced strength of fingers and thumb on left side. Light touch sensation decreased on left side. Phalen's sign positive on left. Patient's medications include Fexmid, Protonix, and Tramadol. Per progress report dated 06/30/15, the patient is working regular duties. For EMG, ACOEM Guidelines page 303 states "Electromyography, including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks." ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11, page 260-262 states: "Appropriate electro diagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful. NCS and EMG may confirm the diagnosis of CTS but may be normal in early or mild cases of CTS. If the EDS are negative, tests may be repeated later in the course of treatment if symptoms persist." ACOEM and MTUS guidelines do not discuss Somatosensory Evoked Potentials. ODG Guidelines, Neck and upper Back chapter, under Somatosensory Evoked Potentials states: "Recommended as a diagnostic option for unexplained myelopathy and/or in unconscious spinal cord injury patients. Not recommended for radiculopathies and peripheral nerve lesions where standard nerve conduction velocity studies are diagnostic. Sensory evoked potentials (SEPs) may be included to assess spinal stenosis or spinal cord myelopathy." Per progress report dated 06/30/15, treater's reason for the request is "to reevaluate the left upper extremity status post left carpal tunnel release." In this case, the patient continues with left hand/fingers, wrist, elbow, and neck pain. Although most upper extremities symptoms and diagnoses are on the left, some are bilateral such as Finkelstein test, Grind test, and de Quervain's disease. EMG study of the RIGHT Upper Extremity would appear reasonable. Prior EMG of the bilateral upper extremities on 02/10/09 was normal. However, there is no indication that the

patient presents with myelopathy, spinal cord injury or spinal stenosis to warrant SSEP for ulnar and median nerves. Therefore, the request IS NOT medically necessary.

NCS (nerve conduction studies) of the right upper extremity (including SSEP for Ulnar and median nerves): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, NCS (nerve conduction studies).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints Page(s): 260-262, 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and upper Back chapter, under Somatosensory Evoked Potentials.

Decision rationale: The patient presents with severe pain in the left hand/fingers, wrist and elbow. Sharp radiating pain from the left elbow to the hand/fingers. Occasional pain in the neck. The request is for NCS (nerve conduction studies) of the right upper extremity (including SSEP for ulnar and median nerves). The request for authorization is dated 07/10/15. The patient is status post left carpal tunnel release, 2007. Status post left dorsal wrist ganglion cyst excision, 2007. EMG/NCS of the bilateral upper extremities, 02/10/09, shows Normal EMG; Abnormal NCS - left mild compression of the median nerve at the carpal tunnel versus normal electrodiagnostic changes after CTS surgery by electrodiagnostic criteria. Physical examination of the elbows and forearms reveal pain on palpation to the left ulnar nerve and left lateral epicondyle and mobile wad. Positive subluxation: cubital tunnel, elbow flexion test, and Tinell's sign on the left. Positive Finkelstein test, direct palp-1st dorsal comp, bilaterally. Direct palpation: scaphoid & lunate positive on left. L-Tq compression test and palpation positive on left. Grind test & CMC-1 stress load positive bilaterally. Reduced strength of fingers and thumb on left side. Light touch sensation decreased on left side. Phalen's sign positive on left. Patient's medications include Fexmid, Protonix, and Tramadol. Per progress report dated 06/30/15, the patient is working regular duties. For EMG, ACOEM Guidelines page 303 states, "Electromyography, including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks." ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11, page 260-262 states: "Appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful. NCS and EMG may confirm the diagnosis of CTS but may be normal in early or mild cases of CTS. If the EDS are negative, tests may be repeated later in the course of treatment if symptoms persist." ACOEM and MTUS guidelines do not discuss Somatosensory Evoked Potentials. ODG Guidelines, Neck and upper Back chapter, under Somatosensory Evoked Potentials states: "Recommended as a diagnostic option for unexplained myelopathy and/or in unconscious spinal cord injury patients. Not recommended for radiculopathies and peripheral nerve lesions where standard nerve conduction velocity studies are diagnostic. Sensory evoked potentials (SEPs) may be included to assess spinal stenosis or spinal cord myelopathy." Per progress report dated 06/30/15, treater's reason for the request is "to reevaluate the left upper extremity status post left carpal tunnel release." In

this case, the patient continues with left hand/fingers, wrist, elbow, and neck pain. Although most upper extremities symptoms and diagnoses are on the left, some are bilateral such as Finkelstein test, Grind test, and de Quervain's disease. NCS study of the right Upper Extremity would appear reasonable. However, prior NCS of the bilateral upper extremities on 02/10/09 showed abnormal NCS - left mild compression of the median nerve at the carpal tunnel versus normal electrodiagnostic changes after CTS surgery by electrodiagnostic criteria. Additionally, there is no indication that the patient presents with myelopathy, spinal cord injury or spinal stenosis to warrant SSEP for ulnar and median nerves. Therefore, the request IS NOT medically necessary.

Somatosensory Evoked Potentials of the Ulnar and Median Nerves qty 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Somatosensory Evoked Potentials.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and upper Back chapter, under Somatosensory Evoked Potentials.

Decision rationale: The patient presents with severe pain in the left hand/fingers, wrist and elbow. Sharp radiating pain from the left elbow to the hand/fingers. Occasional pain in the neck. The request is for somatosensory evoked potentials of the ulnar and median nerves QTY 1.00. The request for authorization is dated 07/10/15. The patient is status post left carpal tunnel release, 2007. Status post left dorsal wrist ganglion cyst excision, 2007. EMG/NCS of the bilateral upper extremities, 02/10/09, shows Normal EMG; Abnormal NCS - left mild compression of the median nerve at the carpal tunnel versus normal electrodiagnostic changes after CTS surgery by electrodiagnostic criteria. Physical examination of the elbows and forearms reveal pain on palpation to the left ulnar nerve and left lateral epicondyle and mobile wad. Positive subluxation: cubital tunnel, elbow flexion test, and Tinel's sign on the left. Positive Finkelstein test, direct palp-1st dorsal comp, bilaterally. Direct palpation: scaphoid & lunate positive on left. L-Tq compression test and palpation positive on left. Grind test & CMC- 1 stress load positive bilaterally. Reduced strength of fingers and thumb on left side. Light touch sensation decreased on left side. Phalen's sign positive on left. Patient's medications include Fexmid, Protonix, and Tramadol. Per progress report dated 06/30/15, the patient is working regular duties. ACOEM and MTUS guidelines do not discuss Somatosensory Evoked Potentials. ODG Guidelines, Neck and upper Back chapter, under Somatosensory Evoked Potentials states: "Recommended as a diagnostic option for unexplained myelopathy and/or in unconscious spinal cord injury patients. Not recommended for radiculopathies and peripheral nerve lesions where standard nerve conduction velocity studies are diagnostic. Sensory evoked potentials (SEPs) may be included to assess spinal stenosis or spinal cord myelopathy." Per request for authorization form dated 07/10/15, treater's reason for the request is "Generalized analysis of the somatosensory nervous system; To determine a response based upon sensory stimulation; To obtain additional information regarding the possible dysfunction at the level of the peripheral nerve, brachial plexus, cervical spinal root & spinal cord." However, there is no indication that the patient presents with myelopathy, spinal cord injury or spinal stenosis to warrant such testing. Therefore, the request IS NOT medically necessary.