

Case Number:	CM15-0208951		
Date Assigned:	10/27/2015	Date of Injury:	05/20/2012
Decision Date:	12/08/2015	UR Denial Date:	09/25/2015
Priority:	Standard	Application Received:	10/23/2015

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, Indiana, New York
 Certification(s)/Specialty: Internal 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 injured worker is a 59-year-old male, who sustained an industrial injury on 5-20-2012. The injured worker is being treated for rotator cuff-tendinosis left shoulder, contusion-sprain left wrist, old fracture middle 3rd ulna healed, and contusion-sprain left elbow. Treatment to date has included diagnostic testing, medications, inferential unit (IF 4), epidural injection, 21 sessions of chiropractic care (as of 7-22-2015) and 15 sessions of acupuncture (as of 7-22-2015). Per the Primary Treating Physician's Progress Report dated 7-22-2015 the injured worker reported increased low back pain with increased bilateral lower extremity numbness. He also reported neck pain with radiation to the upper back, upper back pain, left shoulder pain and left wrist, hand and digit pain. Objective findings of the left upper extremity included tenderness to palpation of the rotator cuff muscles of the left shoulder, minimal tenderness to the left elbow, full range of motion with pain and negative Tinel's, tenderness to palpation of the middle ulna and tenderness to palpation of the left wrist, full range of motion with pain and a questionable Tinel's. Per the medical records dated 3-30-2015 to 7-22-2015 there is no documentation of functional improvement including improvement in symptoms, increase in activities of daily living or decrease in pain level with the current treatment. The notes from the provider do not document efficacy of the prescribed medications. Work status was deferred to PTP. The plan of care included diagnostic testing including electrocardiogram (EKG), EMG (electromyography) - NCS (nerve conduction studies) of the left upper extremity and updated magnetic resonance imaging (MRI) of the lumbar spine. Authorization was requested for EMG and NCS of the left upper extremity to rule out carpal tunnel syndrome. On 9-25-2015, Utilization Review non-certified the request for EMG and NCS of the left upper extremity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electromyography (EMG)/Nerve Conduction Study (NCS) of Left upper extremity to rule out carpal tunnel syndrome: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck section, EMG/NCS.

Decision rationale: Pursuant to the Official Disability Guidelines, EMG/NCV of the left upper extremity is not medically necessary. The ACOEM states (chapter 8 page 178) unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Nerve conduction studies are 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-neuropathies if other diagnoses may be likely based on physical examination. Nerve conduction studies are recommended in patients with clinical signs of carpal tunnel syndrome may be candidates for surgery. EMGs are recommended only in cases where diagnosis is difficult with nerve conduction studies. In more difficult cases, EMG may be helpful as part of electrodiagnostic studies which include nerve conduction studies. Seldom it is required that both studies (EMG and NCV) be accomplished in straightforward conditions of median and ulnar neuropathies or peroneal nerve compression neuropathies. In this case, the injured worker's relevant working diagnoses are post-concussion syndrome; posttraumatic cephalgia; headaches; and contusion/brain left wrist; degenerative joint disease left wrist. For additional diagnoses CV July 22, 2015 list of diagnoses. Date of injury is May 20, 2012. Request for authorization is July 22, 2015 that was resubmitted on September 21, 2015. According to a July 22, 2015 progress note, subjective complaints include the pain that radiates to the upper back, upper back pain, low back pain, left shoulder pain and left wrist/hand/digit pain. Objectively, there is left wrist tenderness to palpation with a questionable positive Tinel's and a negative Finklestein's. There were no other neurologic physical findings documented. According to an August 31, 2015 progress note, there are similar subjective and objective clinical findings, but no request for EMG/NCV of the left upper extremities. Nerve conduction studies are recommended in patients with clinical signs of carpal tunnel syndrome may be candidates for surgery. There is no clinical discussion in the medical record of anticipated surgery. EMGs are recommended only in cases where diagnosis is difficult with nerve conduction studies. There is no clinical indication at the present time for nerve conduction studies. There is no clinical indication of the present time for EMGs. Based on the clinical

information in the medical record, peer-reviewed evidence-based guidelines, no clinical discussion of anticipated surgery for carpal tunnel syndrome, no clinical indication or rationale for nerve conduction studies and no clinical indication or rationale for EMGs, EMG/NCV of the left upper extremity is not medically necessary.

Referral to neurologist for evaluation secondary to persistent headaches: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM 2004 Occupational medicine practice guidelines, Independent medical examinations and consultations, Chapter 7, Page 127.

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): Initial Approaches to Treatment.

Decision rationale: Pursuant to the ACOEM, referral neurologist for evaluation secondary to persistent headaches is not medically necessary. An occupational health practitioner may refer to other specialists if the diagnosis is certain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A consultation is designed to aid in the diagnosis, prognosis and therapeutic management of a patient. The need for a clinical office visit with a healthcare provider is individualized based upon a review of patient concerns, signs and symptoms, clinical stability and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medications such as opiates; antibiotics require close monitoring. In this case, the injured worker's relevant working diagnoses are post concussion syndrome; posttraumatic cephalgia; headaches; and contusion/brain left wrist; degenerative joint disease left wrist. For additional diagnoses CV July 22, 2015 list of diagnoses. Date of injury is May 20, 2012. Request for authorization is July 22, 2015 that was resubmitted on September 21, 2015. According to a July 22, 2015 progress note, subjective complaints include the pain that radiates to the upper back, upper back pain, low back pain, left shoulder pain and left wrist/hand/digit pain. There were no subjective complaints of headache in the medical record documentation. Objectively, there is left wrist tenderness to palpation with a questionable positive Tinel's and a negative Finklestein's. There were no other neurologic physical findings documented. The documentation shows that was an incomplete neurologic physical examination in the medical record. Other than a questionable positive Tinel's and a negative Finklestein's, there were no other neurologic physical findings. Based on the clinical information in the medical record, peer-reviewed evidence-based guidelines, no subjective documentation of headache in the July 22, 2015 progress note, and an incomplete objective neurologic physical examination, referral neurologist for evaluation secondary to persistent headaches is not medically necessary.