

Case Number:	CM150219765		
Date Assigned:	11/12/2015	Date of Injury:	01/14/2013
Decision Date:	12/22/2015	UR Denial Date:	10/30/2015
Priority:	Standard	Application Received:	11/09/2015

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: North Carolina
 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 is a 60 year old female who sustained an industrial injury on 01/14/2013. Medical records indicated the worker was treated for numbness and tingling and discomfort in the hand and digits in the left upper extremity. Examination of the right hand and shoulder shows full range of motion of the right shoulder without pain, full range of motion of the right elbow without swelling or erythema, negative Tinel's about the elbow. There was mild tenderness to the medial epicondyles. The right hand has full motion of the digits, 2 prong intact all digits, negative Tinel's at the wrist with no swelling at the carpal tunnel site, and good strength of the thenar and intrinsics. Her diagnoses include adhesive capsulitis of right shoulder, lesion of ulnar nerve, right upper limb, medial epicondylitis, right elbow, carpal tunnel syndrome, right upper limb. She is status post manipulation under anesthesia, right shoulder 09/15/2014, and progressing well with mild occasional symptoms. The right wrist is status post release, right radial nerve and carpal tunnel June 2013 with persistent numbness, essentially unchanged. She is status post ulnar nerve transposition 04/20/14 with some persistent symptoms. There is essentially persistent unchanged subjective neuritis, Medial epicondylitisgolfer's elbow, status post epicondylectomy surgery, progressing well. The treatment plan included no specific diagnostic testing or treatment for the right upper extremity. The persistent left upper extremity symptoms are a candidate for electrodiagnostic studies. A request for authorization was submitted for Electrodiagnostic study for the left upper extremity. A utilization review decision 10/30/2015 nonauthorized the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electrodiagnostic study for the left upper extremity: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on NonMTUS Citation Official Disability Guidelines (ODG), NCS.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies.

Decision rationale: The ACOEM chapter on neck and upper back complaints and special diagnostic studies states: Criteria for ordering imaging studies are: Emergence of a red flag Physiologic evidence of tissue insult or neurologic dysfunction Failure to progress in a strengthening program intended to avoid surgery Clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies 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. Electromyography (EMG), and nerve conduction velocities (NCV), including Hreflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. The assessment may include sensoryevoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected. If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps, including the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, compute tomography [CT] for bony structures). Additional studies may be considered to further define problem areas. The recent evidence indicates cervical disk annular tears may be missed on MRIs. The clinical significance of such a finding is unclear, as it may not correlate temporally or anatomically with symptoms. The provided documentation does not show any signs of emergence of red flags. There is evidence of neurologic dysfunction on exam. There is no mention of planned invasive procedures. There are no subtle neurologic findings listed on the physical exam. Conservative treatment has not been exhausted. For these reasons criteria for special diagnostic testing has not been met per the ACOEM. Therefore the request is not medically necessary.