

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM15-0041069 | | |
| Date Assigned: | 03/11/2015 | Date of Injury: | 06/03/1998 |
| Decision Date: | 04/15/2015 | UR Denial Date: | 02/24/2015 |
| Priority: | Standard | Application Received: | 03/04/2015 |

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 61-year-old female with an industrial injury dated June 3, 1998. The injured worker diagnoses include status post right carpal tunnel release, status post left thumb carpometacarpal joint excisional arthroplasty, status post interpositional arthroplasty of the left wrist scaphotrapezial joint, stenosing tenosynovitis of the left thumb, bilateral cubital tunnel syndrome, scapholunate disassociation on the wrist, cervical osteoarthritis, probable cervical radiculitis, scaphotrapezoid osteoarthritis, new diagnosis carpal tunnel syndrome on the left, and recurrent carpal tunnel syndrome on the right. She has been treated with diagnostic studies, radiographic imaging, prescribed medications, splint and periodic follow up visits. According to the progress note dated 2/9/2015, the injured worker reported that the right hand awakens her at night and goes numb. The treating physician noted that the injured worker had a carpal tunnel release on the right and symptoms are now reoccurring. Thenar atrophy was noted on the right. Objective findings revealed tenderness on the left carpal metacarpal joint and positive Phalen on the right. Treatment plan consists of Electromyography (EMG) and Nerve conduction velocity (NCV) of the right upper extremity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electromyography/Nerve Conduction Velocity Study for the right upper extremity as an outpatient: 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 Page(s): 178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck section, EMG/NCV.

Decision rationale: Pursuant to the Official Disability Guidelines, EMG/NCV right upper extremity as an outpatient is not medically necessary. The ACOEM states (chapter 8 page 178) unequivocal findings that identifies 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. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy. While cervical electrodiagnostic studies are not necessary to demonstrate his cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality, diabetic property or some problem other than cervical radiculopathy. In this case, the injured worker's working diagnosis are status post right carpal release October 25, 2001; status post left thumb carpo-metacarpal joint excisional arthroplasty February 7, 2002; status post interpositional arthroplasty left wrist scaphotrapezial joint October 25, 1996; stenosis tenosynovitis left thumb; bilateral cubital tunnel syndrome (per electrodiagnostic study September 10, 2012); scapholunate dissociation of the left wrist; cervical osteoarthritis, probable cervical radiculitis; scaphotrapeziod osteoarthritis; and new diagnosis of carpal tunnel syndrome on the left. Documentation does not contain adequate clinical information and the clinical rationale indicating why repeat EMG/NCV studies are clinically indicated. EMG/NCV these are indicated when there is a failure of conservative treatment. There was no conservative treatment rendered to the injured worker. Additionally, the injured worker has had multiple surgeries to be affected wrist (see diagnoses for dates). The injured worker has undergone multiple surgeries in the affected extremity and there is no clinical rationale to repeat EMG/NCV of the upper extremity when the latest EDS was performed September 10, 2012. Additionally, the request for EMG/NCV is for the bilateral right and left upper extremity. Consequently, absent clinical documentation with a clinical rationale and conservative treatment with a prior EDS performed September 10, 2012, EMG/NCV right upper extremity as an outpatient is not medically necessary.