

Case Number:	CM15-0046451		
Date Assigned:	03/18/2015	Date of Injury:	06/29/2000
Decision Date:	07/02/2015	UR Denial Date:	02/17/2015
Priority:	Standard	Application Received:	03/10/2015

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 66 year old male, who sustained an industrial injury on 6/29/00. He has reported initial complaints of upper extremities injury at work. The diagnoses have included carpal tunnel syndrome of the bilateral wrists status post bilateral carpal tunnel release and right index finger, right long finger, left index finger and left thumb entrapment tenosynovitis. Treatment to date has included medications, diagnostics, orthopedic surgeon, and surgery of bilateral wrists. Currently, as per the physician progress note dated 2/2/15, the injured worker complains of 10 year history of bilateral wrist pain with occasional numbness and tingling in the left hand only. He states that sometimes he is unable to close his digits and make a fist. It is noted that he has lost quite a bit of dexterity. He also has locking and popping of the right index finger, right long finger, left thumb and left index finger joints. He has not had any therapy or injections thus far but was given Celebrex. The physical exam reveals that the left elbow has tenderness to palpation and range of motion is as follows: flexion 140 degrees, extension 0 degrees, and pronation and supination 80 degrees. The right elbow exam reveals tenderness to palpation and range of motion as follows: Flexion 140 degrees, extension 0 degrees, and pronation and supination 80 degrees. The exam of the hand and wrist reveals decreased right index finger, left thumb finger and left long finger motion. The two point discrimination is approximately 6 millimeters in all digits. Jamar strength is 80 on the right and 40 on the left. Key pinch is 10 on the right and 15 on the left. There is tenderness to palpation at the A1 pulleys of the right index finger, right long finger, left thumb and left index finger with palpable tendon nodules. The injured worker was given right index finger, right long finger, left thumb and left index finger cortisone injections. The current medications included Voltaren and Prilosec. There was no previous diagnostic studies noted in the records and there was no previous therapy sessions noted. The physician requested treatment included Electromyography/Nerve Conduction Velocity test to bilateral upper extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electromyography/Nerve Conduction Velocity test to bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 261.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173.

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 H-reflex 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 sensory-evoked 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 or subtle physiologic evidence of tissue insult or neurologic dysfunction. There is no mention of planned invasive procedures. There are no subtle neurologic findings listed on the physical exam. For these reasons criteria for special diagnostic testing has not been met per the ACOEM. Therefore the request is not medically necessary.