

Case Number:	CM15-0050996		
Date Assigned:	03/24/2015	Date of Injury:	04/11/2014
Decision Date:	05/01/2015	UR Denial Date:	02/25/2015
Priority:	Standard	Application Received:	03/17/2015

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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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 60-year-old female, who sustained an industrial injury on 04/11/2014, when a metal door hit her right hand. On provider visit dated 01/20/2015 the injured worker has reported right hand pain that extends up towards the right elbow and her right shoulder. On examination of her right upper extremity, she was noted to have a positive Tinel's sign at the cubital tunnel region, positive flexion's test, altered sensation extending along the ulnar aspect of her forearm and altered sensation along the medial aspect of her arm. She was noted to have a decreased range of motion of right wrist and fingers, also noted was a decreased sensation of her entire hand since her carpal tunnel surgery, tingling of her hand as well. Some pillar tenderness over the hyposthenia region was noted. The diagnoses have included residual pain involving her right hand status post carpal tunnel releases, times two, possible right cubital tunnel syndrome, and right hand ulnar neuropathy. Treatment to date has included pain management, carpal tunnel release 2012 and 2013 and right wrist arthroscopy, x-rays and medication. The provider requested a nerve conduction study test and an electromyogram.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electromyogram/nerve conduction study of the right upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007), Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260-262. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Electrodiagnostic testing (EMG/NCS).

Decision rationale: ACOEM 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." ODG states "Recommended needle EMG or NCS, depending on indications. Surface EMG is not recommended. Electromyography (EMG) and Nerve Conduction Studies (NCS) are generally accepted, well-established and widely used for localizing the source of the neurological symptoms and establishing the diagnosis of focal nerve entrapments, such as carpal tunnel syndrome or radiculopathy, which may contribute to or coexist with CRPS II (causalgia), when testing is performed by appropriately trained neurologists or physical medicine and rehabilitation physicians (improperly performed testing by other providers often gives inconclusive results). As CRPS II occurs after partial injury to a nerve, the diagnosis of the initial nerve injury can be made by electrodiagnostic studies." ODG further clarifies "NCS is not recommended, but EMG is recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious." The treating physician notes that the patient has had a previous EMG in 08/2014, which was normal, the treating physician does provide a medical reason a new EMG is needed. As such the request for Electromyogram/nerve conduction study of the right upper extremity is not medically necessary.