

Case Number:	CM15-0083286		
Date Assigned:	05/05/2015	Date of Injury:	08/23/2014
Decision Date:	06/10/2015	UR Denial Date:	04/29/2015
Priority:	Standard	Application Received:	04/30/2015

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 64-year-old female, who sustained an industrial injury on 8/23/2014. She reported a chair she was sitting on tipped over to the right side, injuring the head, neck, right shoulder, elbow, hand and the middle back. Diagnoses include post-concussion syndrome and right shoulder sprain. Treatments to date include medication, activity modification and physical therapy. Currently, she complained of headaches, dizziness, and periods of confusion with intermittent memory loss and word-finding difficulty. She also complained about right arm pain, right shoulder pain and numbness involving the right index finger. On 11/5/14, the neurological physical examination documented she was alert with normal speech, and no abnormal movements. The plan of care included a request for authorization to obtain an electromyogram and nerve conduction studies (EMG/NCS) of the upper extremities to detect potential C6 radiculopathy or median nerve entrapment; and a polysomnography sleep recording.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV bilateral upper extremities to determine any electrical evidence for C6 radiculopathy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), pain chapter.

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 of the bilateral upper extremities to determine any electrical evidence for C6 radiculopathy 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 diagnoses are that is both head trauma; memory impairment; depression; and history of transient ischemic attacks-dysphagia in 2000; and meningioma. The documentation in the medical record, according to an April 8, 2015 progress note, indicates the injured worker complained of headache, confusion and forgetfulness and is being scheduled for a PET scan. The utilization review indicates, according to an April 22, 2015 progress note, a sleep study and EMG was requested by the treating provider. There is no progress note dated April 22, 2015 in the medical record. There are no subjective or objective clinical findings indicative of radiculopathy in the April 8, 2015 progress note. Objectively, there is no objective evidence of radiculopathy. Consequently, absent clinical documentation with subjective and objective clinical findings compatible with cervical radiculopathy, EMG/NCV of the bilateral upper extremities to determine any electrical evidence for C6 radiculopathy medically necessary. Therefore the request is not medically necessary.

Polysomnographic sleep recording: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), pain chapter polysomnography.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Polysomnography.

Decision rationale: Pursuant to the Official Disability Guidelines, polysomnographic sleep recording is not medically necessary. Polysomnography is recommended after at least six months of an insomnia complaint (at least four nights a week), unresponsive to behavior intervention and sedative/sleep promoting medications, and after psychiatric etiology has been excluded. Not recommended for routine evaluation of transient insomnia, chronic insomnia or insomnia associated with psychiatric disorders. The criteria are enumerated in the Official Disability Guidelines. Polysomnography is recommended for the following combination of indications: excessive daytime somnolence; cataplexy; morning headache; intellectual deterioration; personality change; sleep-related breathing disorder; insomnia complaint at least six months (at least four nights a week), etc. in this case, the injured worker's working diagnoses are that is both head trauma; memory impairment; depression; and history of transient ischemic attacks-dysphagia in 2000; and meningioma. The documentation in the medical record, according to an April 8, 2015 progress note, indicates the injured worker complained of headache, confusion and forgetfulness and is being scheduled for a PET scan. The utilization review indicates, according to an April 22, 2015 progress note, a sleep study and EMG was requested by the treating provider. There is no progress note dated April 22, 2015 in the medical record. There are no subjective or objective clinical findings indicative of sleep difficulties in the April 8, 2015 progress note. Objectively, there is no objective evidence of radiculopathy. The injured worker does not have cataplexy, morning headaches (specifically) with other causes ruled out; intellectual deterioration (some, without suspicion of organic dementia); personality change (not secondary to medication, cerebral mass for known psychiatric problems); sleep-related breathing disorder or periodic limb movement disorder; insomnia complaint for at least six months (at least four nights of the week, unresponsive to behavior intervention and sedative/sleep promoting medications and a psychiatric etiology has been excluded. A sleep study with the sole complaint of snoring is not recommended. The progress note dated April 8, 2015 does not contain documentation indicating sleep difficulties, insomnia or other clinical indications for sleep study. Consequently, absent clinical documentation evidencing excessive daytime somnolence; cataplexy; morning headache; intellectual deterioration; personality change; sleep-related breathing disorder; insomnia complaint at least six months (at least four nights a week), etc., polysomnographic sleep recording is not medically necessary.