

Case Number:	CM13-0007244		
Date Assigned:	01/15/2014	Date of Injury:	10/01/2007
Decision Date:	03/19/2014	UR Denial Date:	07/22/2013
Priority:	Standard	Application Received:	08/05/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

Claimant is a 34 year old male with date of injury 10/1/2007. Per neurosurgical re-examination with request for authorization note dated 12/18/2013, the claimant reported ongoing bilateral low back pain, rated at 8/10. He reported radiation of symptoms along the bilateral lower extremities. He denied numbness or tingling in the lower extremities. He reports improvement with physical therapy. On exam his lumbar spine range of motion was flexion 40/60, extension 20/25, right lateral flexion 18/25, and left lateral flexion 20/25. Range of motion was painful and limited upon flexion, extension, right and left lateral flexion. Lower extremity strength was 5/5 throughout and deep tendon reflexes were 2/4. Sensation to light touch and pinprick was noted to be intact over bilateral lower extremities. Diagnoses are status post anterior and posterior lumbar spine fusion and discectomy at L3-L4, L4-L5 (2/11/2013) with residuals. Orthopedic progress report dated 11/26/2013 reports that the claimant complained of low back pain rated at 7/10. On exam lumbar spine range of motion was limited and painful upon flexion, extension, right lateral flexion, and left lateral flexion. Strength of lower extremities was 5/5 on right and 5-/5 on left. Diagnoses include: 1) status post lumbar spine fusion (1/18/2013) 2) bilateral wrist carpal tunnel syndrome 3) low back syndrome 4) abdominal incision infection secondary to lumbar surgery 5) right groin vs. inguinal hernia. Treatment plan included medications and physical therapy. Orthopedic progress note dated 7/16/2013 reported that the claimant complained of right wrist pain of 5/10 and left wrist pain of 2/10 in addition to the low back pain that was reported consistently throughout other clinical notes reviewed. On exam he had a positive Phalen sign and Tinel sign bilaterally. He was diagnosed with bilateral carpal tunnel syndrome, and a request for EMG/NCS of bilateral upper extremities was requested to evaluate his present condition and new onset of pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electromyography (EMG) Bilateral Upper Extremities: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 261-262.

Decision rationale: The claimant has new onset symptoms and physical exam findings that are consistent with bilateral carpal tunnel syndrome. In regard to utilizing EMG and NCS in the evaluation of carpal tunnel syndrome, the ACOEM Guidelines recommend the following: 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. NCS and EMG may confirm the diagnosis of CTS but may be normal in early or mild cases of CTS. If the EDS are negative, tests may be repeated later in the course of treatment if symptoms persist. The American Association of Electrodiagnostic Medicine, the American Academy of Neurology, and the American Academy of Physical Medicine and Rehabilitation jointly published a practice parameter for electrodiagnostic studies in CTS. In patients with suspected CTS, the following EDS studies are recommended: 1. Perform a median sensory NCS across the wrist with a conduction distance of 13 to 14 centimeters. If the result is abnormal, compare the result of the median sensory NCS to the result of a sensory NCS of one other adjacent sensory nerve in the symptomatic limb. 2. If the initial median sensory NCS across the wrist has a conduction distance greater than 8 cm and the result is normal, one of the following additional studies is recommended: a. Comparison of median-sensory- or mixed-nerve conduction across the wrist over a short (7 to 8 cm) conduction distance with ulnar sensory-nerve conduction across the wrist over the same 7- to 8-cm conduction distance b. Comparison of median-sensory conduction across the wrist with radial- or ulnar-sensory conduction across the wrist in the same limb c. Comparison of median-sensory or mixed-nerve conduction through the carpal tunnel to sensory- or mixed-nerve conduction velocity of proximal (forearm) or distal (digit) segments of the median nerve in the same limb The request for Electromyography (EMG) Bilateral Upper Extremities is consistent with the recommendations of these guidelines and is determined to be medically necessary.

Nerve Conduction Study (NCS) Bilateral Upper Extremities: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 261-262.

Decision rationale: The claimant has new onset symptoms and physical exam findings that are consistent with bilateral carpal tunnel syndrome. In regard to utilizing EMG and NCS in the evaluation of carpal tunnel syndrome, the ACOEM Guidelines recommend the following: 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. NCS and EMG may confirm the diagnosis of CTS but may be normal in early or mild cases of CTS. If the EDS are negative, tests may be repeated later in the course of treatment if symptoms persist. The American Association of Electrodiagnostic Medicine, the American Academy of Neurology, and the American Academy of Physical Medicine and Rehabilitation jointly published a practice parameter for electrodiagnostic studies in CTS. In patients with suspected CTS, the following EDS studies are recommended: 1. Perform a median sensory NCS across the wrist with a conduction distance of 13 to 14 centimeters. If the result is abnormal, compare the result of the median sensory NCS to the result of a sensory NCS of one other adjacent sensory nerve in the symptomatic limb. 2. If the initial median sensory NCS across the wrist has a conduction distance greater than 8 cm and the result is normal, one of the following additional studies is recommended: a. Comparison of median-sensory- or mixed-nerve conduction across the wrist over a short (7 to 8 cm) conduction distance with ulnar sensory-nerve conduction across the wrist over the same 7- to 8-cm conduction distance b. Comparison of median-sensory conduction across the wrist with radial- or ulnar-sensory conduction across the wrist in the same limb c. Comparison of median-sensory or mixed-nerve conduction through the carpal tunnel to sensory- or mixed-nerve conduction velocity of proximal (forearm) or distal (digit) segments of the median nerve in the same limb The request for Nerve Conduction Study (NCS) Bilateral Upper Extremities is consistent with the recommendations of these guidelines and is determined to be medically necessary.