

Case Number:	CM14-0149499		
Date Assigned:	09/18/2014	Date of Injury:	03/23/2010
Decision Date:	11/05/2014	UR Denial Date:	08/19/2014
Priority:	Standard	Application Received:	09/15/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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/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:

The injured worker is a 66-year-old male who reported an injury on 03/23/2010 due to an unknown mechanism. Diagnoses were status post surgery left little finger PIP joint traumatic arthritis, and possible left cubital tunnel syndrome. Physical examination on 08/06/2014 reported that the injured worker had numbness in the left little finger as well as numbness along the ulnar border of the left hand. It was recommended that the injured worker have electrodiagnostic testing of the left upper extremity. Examination revealed full composite flexion of the left little finger with 40 degree extension lag of the PIP joint with flexion contracture. Tinel's was negative at the ulnar nerve, left elbow, and wrist. Tinel's was negative at the median nerve left wrist. Sensation was normal. Physical therapy note reported that the injured worker had 5/10 to 6/10 pain to the ulnar hand intermittently. The injured worker had attended 16/24 authorized therapy visits. Treatment plan was to finish physical therapy and request electrodiagnostic testing of the left upper extremity. The rationale and Request for Authorization were not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG of the right upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-269. Decision based on Non-MTUS Citation Official

Disability Guidelines (ODG) Treatment Index, 11th Edition (web), 2014, Forearm, Wrist & Hand Electrodiagnostic studies (EDS)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

Decision rationale: The decision for EMG of the right upper extremity is not medically necessary. The California ACOEM states the 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, and 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 test, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than 3 or 4 weeks. The assessment may include sensory evoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected. There was no emergence of a red flag on the physical examination for the injured worker. There was no physiologic evidence of tissue insult or neurologic dysfunction. It was not reported that the injured worker had failure to progress in the strengthening program. There were no significant factors provided to justify the decision for EMG of the right upper extremity. Therefore, this request is not medically necessary.

NCV of the right upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-269. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Index, 11th Edition (web), 2014, Forearm, Wrist & Hand Electrodiagnostic studies (EDS)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

Decision rationale: The decision for NCV of the right upper extremity is not medically necessary. The California ACOEM states the 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, and 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 test, may help identify subtle focal neurologic

dysfunction in patients with neck or arm symptoms, or both, lasting more than 3 or 4 weeks. The assessment may include sensory evoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected. There was no emergence of a red flag on the physical examination for the injured worker. There was no physiologic evidence of tissue insult or neurologic dysfunction. It was not reported that the injured worker had failure to progress in the strengthening program. There were no significant factors provided to justify the decision for NCV of the right upper extremity. Therefore, this request is not medically necessary.

NCV of the left upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-269. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Index, 11th Edition (web), 2014, Forearm, Wrist & Hand Electrodiagnostic studies (EDS)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

Decision rationale: The decision for NCV of the left upper extremity is not medically necessary. The California ACOEM states the 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, and 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 test, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than 3 or 4 weeks. The assessment may include sensory evoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected. There was no emergence of a red flag on the physical examination for the injured worker. There was no physiologic evidence of tissue insult or neurologic dysfunction. It was not reported that the injured worker had failure to progress in the strengthening program. There were no significant factors provided to justify the decision for NCV of left upper extremity. Therefore, this request is not medically necessary.

EMG of the left upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-269. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Index, 11th Edition (web), 2014, Forearm, Wrist & Hand Electrodiagnostic studies (EDS)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

Decision rationale: The decision for EMG of the left upper extremity is not medically necessary. The California ACOEM states the 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, and 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 test, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than 3 or 4 weeks. The assessment may include sensory evoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected. There was no emergence of a red flag on the physical examination for the injured worker. There was no physiologic evidence of tissue insult or neurologic dysfunction. It was not reported that the injured worker had failure to progress in the strengthening program. There were no significant factors provided to justify the decision for EMG of the left upper extremity. Therefore, this request is not medically necessary.