

Case Number:	CM15-0111472		
Date Assigned:	06/17/2015	Date of Injury:	05/05/2007
Decision Date:	07/17/2015	UR Denial Date:	05/15/2015
Priority:	Standard	Application Received:	06/09/2015

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 31 year old male, who sustained an industrial injury on 05/05/2007. Medical records provided by the treating physician did not indicate the injured worker's mechanism of injury. The injured worker was diagnosed as having status post mid back surgery, left shoulder impingement with adhesive capsulitis, left wrist tendonitis, chronic low back pain, left hand digit extension, severe right carpal tunnel syndrome, severe left upper extremity brachial plexus injury affecting from cervical five through thoracic one nerve roots, along with depression, anxiety, and difficulty sleeping. Treatment and diagnostic studies to date has included above noted procedure, electromyogram performed on 02/06/2012, and medication regimen. In a progress note dated 03/30/2015 the treating physician reports complaints of pain to the left hand, left wrist, left shoulder, and low back along with associated symptoms of numbness and tingling to the left hand and wrist, depression, anxiety, and difficulty sleeping. Examination reveals tenderness to the left trapezius, the left acromioclavicular joint, the left supraspinatus tendon, left wrist, and to the lumbar paraspinal muscles, along with positive impingement to the left shoulder, a right middle trigger finger, weakness to the left hand with drop wrist, painful range of motion to the lumbar spine, and muscle guarding and spasms to the lumbar spine. The injured worker's pain level was rated a 7 out of 10 to the left hand and wrist, a 6 out of 10 to the left shoulder, and a 9 out of 10 to the low back. The treating physician requested electromyogram with a nerve conduction velocity of the upper extremities to evaluate his left brachial plexus and to compare this study to the one performed on 02/06/2012.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 EMG/NCV of the upper extremities: Upheld

Claims Administrator 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 and Upper Back (Acute & Chronic): Electrodiagnostic Studies.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173-174.

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. There is evidence of neurologic dysfunction on exam. There is no mention of planned invasive procedures. There are no subtle neurologic findings listed on the physical exam. Conservative treatment has not been exhausted. For these reasons criteria for special diagnostic testing has not been met per the ACOEM. Therefore, the request is not medically necessary.