

Case Number:	CM15-0172521		
Date Assigned:	09/14/2015	Date of Injury:	06/01/1991
Decision Date:	10/13/2015	UR Denial Date:	08/21/2015
Priority:	Standard	Application Received:	09/01/2015

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 65 year old female, who sustained an industrial injury on 6-1-91. The injured worker was diagnosed as having post-surgical segmental dysfunction lumbar; sciatica no disc involvement; brachial neuritis, no disc involvement; segmental dysfunction sacroiliac region (Acquired). Treatment to date has included physical therapy; medications. Currently, the PR-2 notes dated 8-7-15 indicated the injured worker was in the office for a re-examination. The provider documents the injured worker had been experiencing increased low back pain, left leg, left arm pain and numbness in the fingers of her left hand for six weeks which failed to respond to home regimen of exercise, stretching and ice. He did not have a new injury, but the provider notes; he "suffered an unprovoked flare up of the 6-1-91 industrial injury". The provider notes the pain resulted in a functional deficit not allowing the injured worker to bend forward, back, right or left. She cannot tilt her neck back or to the left without acute moderate pain. The provider notes that re-examination of the injured worker on 7-22-15 reveals she has experienced improvement of her lower back, left leg, left arm pain. He notes her functional deficit not allowing the injured worker to bend forward, back, right or left. She cannot tilt her neck back or to the left without acute moderate pain. The provider then documents a re-examination on 8-7-15 reveals the injured worker experienced improvement of her lower back, left leg, and left arm pain. The pain resulted in a functional deficit not allowing her to bend back, tilt her neck to the left without pain. Objective findings are documented by the provider for an exam on 6-12-151 with positive shoulder depressor on the left, positive foraminal compression test on the left, positive Kemp's test on the left, positive Goldthwaite's test on the left (lumbar), positive iliac

compression test on the left, spasm of the cervical and lumbar musculature, lumbar right and left lateral flexion decreased by 20%, lumbar extension decreased by 35%, lumbar flexion decreased by 25%, cervical left lateral flexion decreased by 40%, cervical extension decreased by 35%. Exam on 7-25-15 documented change in spasm of cervical musculature, lumbar extension decreased by 25%, lumbar flexion decreased 25%, cervical left lateral flexion decreased by 25%, cervical extension decreased by 20%. Exam note on 8-7-15 notes a change in the lumbar extension decreased by 20%, cervical left lateral flexion decreased by 20%. The provider documents the injured worker's prognosis is poor and continues to require supportive care to minimize her functional deficit and allow her to function at or near "P and S Level". The treatment plan included a short-term goal of treating flare-ups as they occur. Long term goal is to keep her at or near P and S level for pain and functional deficit with progression toward a self- directed program. The provider's treatment included examination, evaluation, spinal manipulation, soft tissue manipulation, myofascial release, manual traction, mechanical traction, massage, and rehabilitative exercise. He is requesting the nerve conduction test on her left upper extremity due to the numbness in her left middle finger is increasing. A Request for Authorization is dated 9-8-15. A Utilization Review letter is dated 8-21-15 and non-certification was for a Nerve conduction test for the left upper extremity. Utilization Review non-certified the nerve conduction tests stating: "Review of documentation did not reveal objective findings suggesting carpal tunnel syndrome. In addition, documentation did not reveal the patient has a closed fracture of the distal radius and ulna, as well as no traumatic nerve lesion. Documentation noted increased left middle finger numbness; however, documentation did not reveal the patient has a traumatic injury to cause increased middle finger numbness. In additional, objective findings did not reveal any nerve impairment for the left upper extremity. Documentation also did not reveal possible ulnar nerve injury at the wrist and that surgical treatment was being considered." The provider is requesting authorization of a Nerve conduction test for the left upper extremity.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Nerve conduction test for the left upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist and Hand (Acute and Chronic), Electrodiagnostic studies (EDS).

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck section, EMG/NCV.

Decision rationale: Pursuant to the Official Disability Guidelines, one nerve conduction test for the left upper extremity is not medically necessary. The ACOEM states (chapter 8 page 178) unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging if symptoms persist. Nerve conduction studies and mutilated 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 neuropathy or some problem other than cervical radiculopathy. In this case, the injured worker's working diagnoses are postsurgical segmental dysfunction lumbar; sciatica, no disk involvement; brachial neuritis, no disc involvement; and segmental dysfunction, sacroiliac region acquired. Date of injury is June 1, 1991. Request authorization is August 18, 2015. The medical record contains 44 pages. According to an August 7, 2015 progress note, the injured worker's subjective complaints of low back pain, left leg pain, left arm pain and numbness in the left hand back. The left middle finger has experienced numbness that has been increasing. Objectively, there is no neurologic evaluation addressing the upper extremities, no possibility of cubital tunnel or carpal tunnel syndrome of the right and left extremities. There was no documentation with evidence of a prior closed fracture of the distal radius and ulna and no traumatic nerve lesion. Based on the final information in the medical record, peer-reviewed evidence-based guidelines, no objective neurologic examination of the upper extremities, no provocative testing (Tinel's and Phalen's) and no documentation of a prior closed fracture or traumatic nerve lesion, one nerve conduction test for the left upper extremity is not medically necessary.