

Case Number:	CM15-0175648		
Date Assigned:	09/16/2015	Date of Injury:	03/04/2014
Decision Date:	10/19/2015	UR Denial Date:	08/06/2015
Priority:	Standard	Application Received:	09/04/2015

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 54 year old female, who sustained an industrial injury on 03-04-2014. She has reported subsequent neck, left arm and hand pain and numbness and was diagnosed with C4-C5 stenosis with spinal cord compression and myelopathy, C5-C6 and C6-C7 disc degeneration without stenosis, status post C4-C5 partial corpectomy and anterior cervical discectomy and fusion on 04-01-2015. Treatment to date has included oral pain medication, chiropractic treatment and surgery. In a progress note dated 06-29-2015 the injured worker reported ongoing post-operative neck pain extending to the top of the shoulder that was rated as a 5 out of 10 along with significant left hand pain and numbness that was rated as 9-10 out of 10. Objective examination findings showed paresthesia to touch over the left C7-C8 dermatome distribution, decreased cervical range of motion and significantly positive Tinel's sign at the left wrist as well as positive Phalen's sign at the left wrist. The physician noted that the injured worker would continue with post-operative physical therapy for range of motion and strengthening but that the injured worker continued to have ongoing daily and constant severe left wrist and hand pain consistent with recurrent carpal tunnel syndrome. The physician noted that a repeat electromyography (EMG) and nerve conduction study (NCS) of the bilateral upper extremities was being requested to further evaluate signs and symptoms and determine further treatment recommendations. Work status was documented as temporarily totally disabled. A request for authorization of EMG/NCS of the bilateral upper extremities was submitted. At utilization review (08-06-2015), EMG/NCS of the bilateral upper extremities was denied.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCS bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies.

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