

Case Number:	CM15-0178353		
Date Assigned:	09/18/2015	Date of Injury:	03/06/2013
Decision Date:	10/22/2015	UR Denial Date:	08/15/2015
Priority:	Standard	Application Received:	09/10/2015

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 51 year old male who sustained an industrial injury on March 06, 2013. A primary treating office visit dated February 23, 2015 reported current subjective complaint of: bilateral hip, bilateral shoulder, bilateral wrist, bilateral elbow and forearm, low back, neck, and upper back pains. The following diagnoses were applied this visit: bilateral hip strain rule out internal derangement, left worse; lumbar radiculopathy, left worse; cervical strain with left-sided radiculopathy radiculitis; bilateral wrist tendonitis with bilateral carpal tunnel syndrome; bilateral tennis elbow tendinitis medial and lateral with bilateral cubital tunnel syndrome; bilateral shoulder impingement and strain, left worse, rule out tear; thoracic strain, left side worse; left knee pain rule out internal derangement, and left thigh pain. The plan of care is with recommendation for: orthopedic consultation regarding bilateral hip pains; undergo recent magnetic resonance imaging study of cervical spine; continue current medications. Primary follow up dated July 02, 2015 reported the patient's "symptoms remain persistent despite conservative care." "Current medication regimen does allow the patient to continue with activities of daily living so he will continue with that at this time." He reports "having increased intensity of numbness and tingling of the left upper extremity." There is noted discussion regarding 2013 denial of nerve conduction study of bilateral upper extremities along with magnetic resonance imaging study of cervical, thoracic and lumbar regions. Nerve conduction study performed March 27, 2014 revealed negative findings for cervical radiculopathy on either side; positive for bilateral slight carpal tunnel syndromes and also positive for slight to moderate bilateral cubital tunnel syndromes.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electromyograph (EMG) and nerve conduction velocity (NCV) to the left upper extremity:

Upheld

Claims Administrator guideline: Decision based on MTUS Elbow Complaints 2007.

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 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.