Case Number:	CM15-0078878		
Date Assigned:	04/30/2015	**Date of Injury:**	02/01/2010
Decision Date:	06/11/2015	**UR Denial Date:**	03/23/2015
Priority:	Standard	**Application Received:**	04/24/2015

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 56 year old female, who sustained an industrial injury on February 1, 2010. The injured worker was diagnosed as having cervical discopathy with radiculitis, status post bilateral carpal tunnel release with electrodiagnostic evidence of bilateral carpal tunnel syndrome, left shoulder impingement syndrome with labral tear and partial rotator cuff tear, right shoulder impingement syndrome with superior labral tear, right thumb and right thumb, right index finger, and left ring finger triggering, rule out internal derangement of the left hip, and bilateral knee degenerative joint disease. Treatment to date has included bilateral carpal tunnel release and medication. Currently, the injured worker complains of continued symptomatology in the cervical spine, chronic headaches, tension between the shoulder blades, and migraines, with symptomatology in the shoulders, left hip, and knees. The single submitted Primary Treating Physician's report, dated May 20, 2013, noted the injured worker reported using Naproxen as it offered temporary pain relief, allowing her to perform activities of daily living (ADLs), although with complaints of an upset stomach with the Naproxen use. Physical examination was noted to show tenderness at the cervical paravertebral muscles and upper trapezial muscles with spasm, limited cervical range of motion (ROM), positive axial loading compression test and Spurling's maneuver, and dysesthesia at the C5 and C6 dermatomes. Examination of the shoulders was noted to show tenderness anteriorly with positive Hawkin's and impingement signs, and pain with terminal motion. The wrists examination was noted to show tenderness bilaterally with tenderness at the first dorsal compartment greater than the right index finger and left ring A-1 pulley with triggering, and pain at terminal motion. The knees

were noted to have tenderness at the knee joint line bilaterally, with positive patellar compression test, and pain with terminal motion. The left hip was noted to have tenderness in and around the posterolateral region with reproducible symptomatology with internal rotation, external rotation, and pistoning. The injured worker was noted to appear to have progressive neurological deficit in the upper extremities consistent with double crush syndrome, requiring updated diagnostic studies and access to surgical intervention in the form of a surgical decompression and realignment of the C4 through C6 levels and possible junctional level, including carpal tunnel release bilaterally. The treatment plan was noted to include re-request for surgical decompression and realignment of the C4 through C6 levels and possible junctional level, including carpal tunnel release bilaterally, need for preapproval for durable medical equipment, postoperative medication and physical therapy, with recommendation and request for authorization for appropriate diagnostic studies including a MRI of the cervical spine, electromyography (EMG)/nerve conduction velocity (NCV) studies of the bilateral upper extremities, electromyography (EMG)/nerve conduction velocity (NCV) of the bilateral lower extremities, and requests for authorization for medications dispensed, including Naproxen Sodium, Cyclobenzaprine Hydrochloride, Sumatriptan Succinate, Ondansetron ODT, Omeprazole Delayed-Release, Medrox Pain Relief Ointment, and Tramadol Hydrochloride Extended-Release.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electromyogram/Nerve conduction velocity bilateral upper extremities: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

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 meets criteria as outlined above and therefore the request is certified.