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| Case Number: | CM15-0095883 | | |
| Date Assigned: | 05/22/2015 | Date of Injury: | 10/21/2010 |
| Decision Date: | 06/24/2015 | UR Denial Date: | 05/07/2015 |
| Priority: | Standard | Application Received: | 05/18/2015 |

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 30-year-old female, with a reported date of injury of 10/21/2010. The diagnoses include right ulnar nerve entrapment at the elbow, status post right ulnar nerve decompression at the elbow, right small finger metacarpophalangeal (MCP) joint arthralgia, status post MCP joint injection with ultrasound guidance, right ulnar wrist pain, status post injections to the right wrist, and left ulnar nerve entrapment at the elbow. Treatments to date have included electrodiagnostic studies of the bilateral upper extremities on 10/14/2014 with normal findings. The progress report dated 04/29/2015 indicates that the injured worker complained of left small and ring finger numbness and tingling and right wrist decreased pain. The physical examination showed intact sensation to light touch at all digital pulps of the right upper extremity, a well-healed ulnar nerve decompression at the right elbow scar, tenderness to palpation at the right dorsal ulnar wrist, positive Tinel's and flexion test at the left elbow, and diminished light touch at the left ring and small fingers. The treating physician requested a repeat EMG/NCV (electromyography/nerve conduction velocity) of the bilateral upper extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

Repeated EMG/NCS of the bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 261. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back Chapter, Electrodiagnostic studies; Official Disability Guidelines (ODG), Carpal Tunnel Syndrome Chapter, Electrodiagnostic Testing.

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, electro diagnostic 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 medically necessary.