Case Number:	CM14-0173117		
Date Assigned:	10/23/2014	**Date of Injury:**	09/15/1994
Decision Date:	11/25/2014	**UR Denial Date:**	09/25/2014
Priority:	Standard	**Application Received:**	10/20/2014

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 63 year old male who had a work injury dated 9/15/94. The diagnoses include a history of an anterior lumbar L5-S1 interbody fusion; peripheral neuropathy; chronic pancreatitis; L4-5 stenosis; rule out carpal tunnel syndrome vs. radial tunnel syndrome status post radial artery grafting. Under consideration are requests for EMG/NCS for the left upper extremity. There is an 8/14/14 progress note that states that the patient had an acute exacerbation of his chronic low back pain. He denies significant leg pain and weakness. He note left forearm burning with numbness/tingling in his left hand. He had radial arm grafting in his left arm years ago and notes that this became worse over the past month with weakness in gripping. On exam of the left upper arm there is a healed incision in the mid forearm with a positive Tinel over the scar. There is decreased sensation on the volar aspect of all 5 digits. Grip strength is intact. There is a negative Tinel at the carpal tunnel and a positive Phalen. The lumbar paravertebral muscles are tender. There is a negative seated straight leg raise. There is decreased lumbar range of motion.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCS for the left upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Carpal Tunnel Syndrome (Acute & Chronic)- Tests (CTS diagnosis) Dumitru, Daniel. Electrodiagnostic Medicine. Second ed. Philadelphia: Hanley & Belfus, 2002. 1091-1092. Print

Decision rationale: EMG/NCS of the left upper extremity is not medically necessary per the MTUS, ODG and the electrodiagnostic text reference Electrodiagnostic Medicine The documentation indicates that the provider requests a NCS/EMG of the left upper extremity to distinguish between carpal tunnel syndrome and radial tunnel syndrome. According to [redacted] in the text Electrodiagnostic Medicine radial tunnel syndrome is primarily a clinical speculation based on little in the way of objective data. Patients do not demonstrate any documented loss of strength or sensation in any branches of the radial nerve. There is no detailed documentation through electrophysiologic means of neural dysfunction. [redacted] text states that until there are careful controlled surgical studies directed at identifying a focal compromise of the radial nerve by electrophysiologic means, particularly intraoperative studies demonstrating focal conduction abnormalities, credibility cannot be given to this supposed entrapment syndrome. The MTUS ACOEM states that carpal tunnel syndrome does not produce hand or wrist pain. It most often causes digital numbing or tingling primarily in the thumb, index, and long finger or numbness inthe wrist. Symptoms of pain, numbness, and tingling in the hands are common in the general population, but based on studies, only about one in five symptomatic subjects would be expected to have CTS based on clinical examination and electrophysiologic testing. The ODG states that a combination of abnormal Katz hand diagram, abnormal Semmes-Weinstein test, positive Durkan's compression test, and night pain are 96% sensitive and 99% specific while a Phalen test is 55% sensitive and 45% specific. The ACOEM MTUS guidelines states that carpal tunnel syndrome must be proved by positive findings on clinical examination and the diagnosis should be supported by nerve-conduction tests before surgery is undertaken. The documentation does not reveal convincing evidence of carpal tunnel syndrome. The patient has decreased sensation on the volar aspect of all 5 digits which is not consistent with carpal tunnel syndrome. It is also unclear how electrodiagnostic studies will change the management of this patient. The request for EMG/NCS of the left upper extremity is not medically necessary.