

<b>Case Number:</b>	CM14-0005798		
<b>Date Assigned:</b>	02/05/2014	<b>Date of Injury:</b>	03/14/2006
<b>Decision Date:</b>	06/20/2014	<b>UR Denial Date:</b>	12/27/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/13/2014

### 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 Occupational Medicine, and is licensed to practice in California. 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 claimant injured her shoulder and upper arm on 3/14/06. She was diagnosed with a sprain, and underwent nerve conduction studies that revealed bilateral carpal tunnel syndrome and, on 5/21/08, she had right carpal tunnel release. She improved with postoperative physical therapy and returned to work. She was injured again on 6/17/09 while reaching. She had electrodiagnostic studies on 2/24/10 that revealed right carpal tunnel syndrome status post right carpal tunnel release. She had a right wrist MRI and bone scan in 2010. On 3/11/13, she had ongoing wrist pain and limited motion. She was status post arthroscopic surgery with chondroplasty and debridement of her right wrist in December 2012. She had eight visits of therapy and had limited range of motion and tenderness. She had mildly weak grip strength. Additional physical therapy was recommended by [REDACTED] so her shoulder did not stiffen up. She is also status post right cubital tunnel release. She had additional nerve tests on 3/16/11. On 3/16/11, there was evidence of mild right carpal tunnel syndrome and mild left carpal tunnel syndrome. She had moderate to severe right digital radial sensory neuropathy, but no left radial neuropathy. There was no evidence of cervical radiculopathy. The electrodiagnostic studies on 10/10/11 were normal, but showed denervation and reinnervation in the right ulnar territory. She had a clinical diagnosis of right cubital tunnel syndrome. She underwent right elbow cubital tunnel release on 5/09/12 and attended physical therapy with improvement. A note dated 3/27/13 indicates that she was status post right carpal tunnel release. Physical therapy was recommended with modalities. She had impingement of the right shoulder. On 4/12/13, there is a response to a denial of additional physical therapy. An additional eight sessions of physical therapy was ordered for the right shoulder on 7/15/13. An MRI of the cervical spine was also recommended. She reported continued pain in her right shoulder, neck pain with limited movement, and right wrist pain. She had difficulty driving. On 12/17/13, she was evaluated for right upper extremity pain. In December 2012 she underwent arthroscopic exploratory surgery for the right wrist and

there is brief mention that a fracture was found. She has a diagnosis of status post TFCC debridement. She continued to have pain throughout these areas. She had numbness of the right thumb, index, and little fingers. Examination revealed impingement signs and fairly good range of motion of the shoulder. The right wrist also had good range of motion and no significant findings. She had negative Finkelstein's test, Tinel's, and Phalen's tests. Sensation was intact throughout. She reported worsening symptoms in the right upper extremity and EMG/NCS was recommended to evaluate for peripheral nerve compression versus other pathology.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **EMG RIGHT UPPER EXPREMITY: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM PRACTICE GUIDELINES. SECOND EDITION (2004), CHAPTER 8, 178

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE , NECK AND UPPER BACK, ELECTRODIAGNOSTIC STUDIES,

**Decision rationale:** The Official Disability Guidelines (ODG) state that electrodiagnostic studies may be recommended in patients with clinical signs of carpal tunnel syndrome who may be candidates for surgery. Electrodiagnostic testing includes testing for nerve conduction velocities (NCV), but the addition of electromyography (EMG) is not generally necessary. The ODG states that electrodiagnostic studies may also be recommended as an option after closed fractures of distal radius & ulna if necessary to assess nerve injury. In this case, the claimant has had many studies of this type prior to her wrist surgery in December 2012. However, on 12/17/13, one year post-op, no focal neurologic findings were documented by [REDACTED] despite the patient's complaints of symptoms. It is not clear that additional surgery is likely or is under consideration. There is no evidence of a change in the claimant's symptoms or findings over time since her surgery (at which time an occult fracture as found) which would support repeating this study. In addition, there is no evidence that radiculopathy is being ruled out. The California MTUS/ACOEM guidelines state that 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. In this case, the claimant has had repeat EMG studies that did not show radiculopathy, and there is no evidence of focal neurologic deficits involving the cervical spine for which this type of study needs to be repeated. As such, the request is not medically necessary.

#### **NCS RIGHT UPPER EXTREMITY: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM PRACTICE GUIDELINES. SECOND EDITION (2004), CHAPTER 8, 178

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** The Official Disability Guidelines (ODG) state that electrodiagnostic studies may be recommended in patients with clinical signs of carpal tunnel syndrome who may be candidates for surgery. Electrodiagnostic testing includes testing for nerve conduction velocities (NCV), but the addition of electromyography (EMG) is not generally necessary. The ODG states that electrodiagnostic studies may be recommended as an option after closed fractures of distal radius & ulna if necessary to assess nerve injury. In this case, the claimant has had many studies of this type prior to her wrist surgery in December 2012. However, on 12/17/13, one year post-op, no focal neurologic findings were documented by [REDACTED], despite the patient's complaints of symptoms. It is not clear that additional surgery is likely or is under consideration. There is no evidence of a change in the claimant's symptoms or findings over time since her surgery with a finding of an occult fracture which would support repeating this study. As such, the request is not medically necessary.