Case Number:	CM14-0065376		
Date Assigned:	07/11/2014	**Date of Injury:**	07/01/2010
Decision Date:	09/15/2014	**UR Denial Date:**	04/25/2014
Priority:	Standard	**Application Received:**	05/08/2014

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 expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:The patient is a 62-year-old female who has submitted a claim for elbow tendinitis/bursitis, wrist tendinitis/bursitis, left carpal tunnel syndrome, and cervical radiculopathy associated with an industrial injury date of 07/01/2010. Medical records from 03/24/2014 to 07/11//2014 were reviewed and showed that patient complained of neck pain radiating down bilateral upper extremities and bilateral wrist pain with numbness and weakness. Physical examination revealed tenderness over the cervical paravertebral muscles. Decreased cervical spine ROM was noted. Sensation to light touch was decreased over C6, C7, and C8 dermatomes bilaterally. MMT and reflexes of the upper extremities were intact bilaterally. Phalen's and reverse Phalen's tests were positive bilaterally. X-ray of the cervical spine dated 03/04/2014 revealed C4-5 and C5-6 disc space narrowing. X-ray of the right hand dated 03/04/2014 revealed degeneration of the distal joint of the right little finger. X-ray of the left hand dated 03/04/2014 was unremarkable. MRI of the cervical spine dated 10/29/2012 revealed C2-3 and C3-4 mild lateral neural foraminal narrowing, C4-5 disc desiccation with moderate bilateral neural foraminal narrowing, C5-6 disc desiccation and C6-7 disc protrusion to the right and disc desiccation. EMG/NCV of bilateral upper extremities dated 11/14/2011 revealed mild left carpal tunnel syndrome. Treatment to date has included bilateral carpal tunnel release, home exercise program, and pain medications.Utilization review dated 04/25/2014 denied the request for EMG/NCV of bilateral upper extremities because there was no documentation of recent conservative care trial prior to requesting new diagnostic studies.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electromyography (EMG) Bilateral Upper Extremities: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 238.

Decision rationale: According to page 238 of the CA MTUS ACOEM Practice Guidelines, EMG is recommended if cervical radiculopathy is suspected as a cause of lateral arm pain or if severe nerve entrapment is suspected on the basis of physical examination and denervation atrophy is likely. Moreover, guidelines do not recommend EMG before conservative treatment. In this case, the patient complained of neck pain radiating down bilateral upper extremities and bilateral wrist pain with numbness and weakness. Physical examination revealed hypesthesia over C6, C7, and C8 dermatomes. MMT and reflexes of the upper extremities were intact bilaterally. Phalen's and reverse Phalen's tests were positive bilaterally. The patient's clinical manifestations were consistent with a possible focal neurologic deficit to support EMG of bilateral upper extremities. Of note, EMG/NCV of bilateral upper extremities was done (11/14/2011) with documentation of mild left carpal tunnel syndrome. There is no clear indication as to why a repeat EMG is needed. Therefore, the request for Electromyography (EMG) Bilateral Upper Extremities is not medically necessary.

Nerve conduction velocity (NCV) Bilateral Upper Extremities: 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): 261-262. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Nerve Conduction Studies Other Medical Treatment Guideline or Medical Evidence: Nerve Conduction Studies in Polyneuropathy: Practical Physiology and Patterns of Abnormality, Acta Neurol Belg 2006 Jun; 106 (2): 73-81.

Decision rationale: CA MTUS ACOEM Guidelines state that appropriate electrodiagnostic studies may help differentiate between carpal tunnel syndrome and other conditions, such as cervical radiculopathy. These include nerve conduction studies, or in more difficult cases, electromyography may be helpful. Moreover, ODG states that NCS is not recommended to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but is recommended if the EMG is not clearly consistent with radiculopathy. A published study entitled "Nerve Conduction Studies in Polyneuropathy" cited that NCS is an essential part of the work-up of peripheral neuropathies. Many neuropathic syndromes can be suspected on clinical grounds, but optimal use of nerve conduction study techniques allows diagnostic classification and is therefore crucial to understanding and separation of neuropathies. In this case, the patient complained of neck pain radiating down

bilateral upper extremities and bilateral wrist pain with numbness and weakness. Physical examination revealed hypesthesia over C6, C7, and C8 dermatomes. MMT and reflexes of the upper extremities were intact bilaterally. Phalen's and reverse Phalen's tests were positive bilaterally. NCV is a reasonable option for the patient who presented with symptoms of neuropathy. However, EMG/NCV of bilateral upper extremities was done (11/14/2011) with documentation of mild left carpal tunnel syndrome. There is no clear indication as to why a repeat NCV is needed. Therefore, the request for Nerve Conduction Velocity (NCV) Bilateral Upper Extremities is not medically necessary.