

<b>Case Number:</b>	CM14-0117323		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	06/25/2010
<b>Decision Date:</b>	02/06/2015	<b>UR Denial Date:</b>	06/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/25/2014

### 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 Family Practice, and is licensed to practice in North Carolina. 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 55-year-old with a reported injury date of 11/01/2006-07/19/2010. The patient has the diagnoses of cervical discopathy, chronic cervicgia, disc protrusion at C4/5 and C5/6, lumbar discopathy, disc protrusions at L4/5 and L5/S1, bilateral carpal tunnel syndrome, cubital tunnel syndrome and double crush syndrome, 7 mm osteochondritis dessicans in the medial aspect of the radial head, 5 mm subchondral cysts in the distal lateral humeral condyle, fracture versus pseudo fracture of the left wrist capitate, bilateral shoulder impingement, partial tear of the supraspinatus tendon on the left shoulder and likely full thickness tear in the critical insertion zone of the supraspinatus tendon with superior labral tear in the right shoulder.. Per the progress notes from the primary treating physician dated 02/04/2014, the patient had complaints of persistent pain in the neck with headache. The pain radiates to the upper extremities with numbness and tingling. The physical exam noted cervical spine tenderness with positive axial loading tests and Spurling's maneuver. There was dysesthesia at the C5 and C8 dermatome. There was bilateral shoulder tenderness with positive impingement and Hawkin's sign. There was tenderness in the bilateral medial aspect of the elbows with positive Tinel's sign and pain with flexion. There was tenderness in the bilateral dorsal wrists with diminished sensation of the radial digits and pain with flexion. There was tenderness in the lumbar spine and a positive seated nerve root test. There was tenderness in the anterolateral aspect of the right hip and pain with rotation. Treatment plan recommendations included physical therapy and medications. Additional progress notes provided for review are hand written and mostly illegible.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Repeat Electromyography Right Upper Extremity: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 258-262.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173 and 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 does not show any signs of emergence of red flags, the patient has the diagnoses already of bilateral carpal tunnel syndrome and cubital tunnel syndrome and there is not mention of change in symptoms/physical exam or planned surgical procedure. 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.

**Repeat Nerve Conduction Study Right Upper Extremity: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 42 and 43.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173 and 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 does not show any signs of emergence of red flags, the patient has the diagnoses already of bilateral carpal tunnel syndrome and cubital tunnel syndrome and there is not mention of change in symptoms/physical exam or planned surgical procedure. 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 certified.