

<b>Case Number:</b>	CM14-0205239		
<b>Date Assigned:</b>	12/17/2014	<b>Date of Injury:</b>	07/16/2008
<b>Decision Date:</b>	02/05/2015	<b>UR Denial Date:</b>	11/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/08/2014

### 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 Internal 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 injured worker (IW) is a 53-year-old woman with a date of injury of July 16, 2008. The mechanism of injury was a fall resulting in multiple injuries. She sustained injuries to her neck, both hands and elbows. She has numerous procedures over the subsequent years including right shoulder, bilateral carpal tunnel releases, bilateral ulnar transpositions and bilateral trigger finger releases. The IW underwent EMG/NCV April 2009. The findings were chronic right C6-C7 radiculopathy and median nerve pathology at the right wrist. The injured worker's working diagnoses are cervical sprain/strain; and bilateral carpal tunnel syndrome. The IW underwent left carpal tunnel release on March 26, 2010 and right carpal tunnel release on April 23, 2010. Pursuant to a clinical note by the family care physician dated September 16, 2014, the IW complains of constant neck pain and bilateral upper extremity numbness and pain. The bilateral upper extremity numbness is described as constant numbness and paresthesias to both distal bilateral upper extremities, left more than right. Objectively, the neurological examination was normal. The Primary Treating Physician's Progress Report (PR-2) from October 9, 2014 is handwritten and grossly incomplete. The documentation did not contain a comprehensive neurologic or musculoskeletal evaluation. The current request is for EMG/NCV 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:

**EMG (electromyography)/NCV (nerve conduction velocity) of the bilateral upper extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back (Acute & Chronic), Electromyography

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Neck /Carpal Tunnel Syndrome, NCV/EMG.

**Decision rationale:** Pursuant to the Official Disability Guidelines, EMG/NCV of the bilateral upper extremities is not medically necessary. NCV is not recommended to demonstrate radiculopathy has already been clearly identified by DMT and obvious clinical signs, but recommended if the EMG is not clearly radiculopathy or clearly negative or to differentiate radiculopathy from other neuropathies or non-neuropathy diagnoses likely based on clinical examination. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy. NCV are recommended in patients with clinical signs of carpal tunnel syndrome may be candidates for surgery. Carpal tunnel syndrome must be proved by physical findings on clinical exam and should be supported by nerve conduction tests before surgery is undertaken. In this case, the injured worker is a 53-year-old woman with a date of injury July 16, 2008. The injured worker's working diagnoses are bilateral carpal tunnel syndrome; and cervical sprain/strain. She underwent EMG/NCV April 2009. The findings were chronic right C6 - C7 radiculopathy and median nerve pathology at the right wrist. The injured worker underwent left carpal tunnel release surgery March 26 of 2010 and right carpal tunnel release surgery April 23 of 2010. The primary treating physician's progress note from October 9, 2014 is handwritten and grossly incomplete. The documentation did not contain a comprehensive neurologic or musculoskeletal evaluation. Consequently, absent a complete clinical neurologic and musculoskeletal evaluation and the long-term presence of a cervical radiculopathy, EMG/NCV of the bilateral upper extremities is not medically necessary.