Case Number:	CM15-0100838		
Date Assigned:	06/03/2015	**Date of Injury:**	02/18/2015
Decision Date:	07/09/2015	**UR Denial Date:**	05/14/2015
Priority:	Standard	**Application Received:**	05/26/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: Iowa, Illinois, Hawaii
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive Medicine

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 is a 51 year old female, who sustained an industrial injury on 2/18/15. She reported initial complaints of left upper extremity thumb, finger and palm with pain and numbness. The injured worker was diagnosed as having wrist sprain/strain; pain in soft tissue of limb; overuse syndrome left upper extremity; Positive Waddell's signs; left shoulder sprain/strain/impingement; left wrist sprain/strain/enthesopathy; left thumb sprain/strain/tenosynovitis. Treatment to date has included splint, sling, ace wrap for left arm; medications. Currently, the PR-2 notes dated 3/17/15 indicated the injured worker complains of pain in the left thumb, finger and arm with numbness. Her left shoulder/upper arm has constant pain rated at 8/10 and very stiff making it difficult to use noting she could not lift her arm to her shoulder height. The pain is reported to "move around." The pain is reported to move down the arm with numbness in the fingers. With repetitive use or forceful use of her arm the pain can become as high as 10/10. The left distal forearm is noted as constant pain rated at 6/10. The left thumb has constant pain and numbness rated at 2-8/10 in intensity. She reports she is unable to carry anything due to the left thumb pain and weakness with gripping and grasping. She is using a splint every day and currently taking Ibuprofen, Metoprolol, Amlodipine and Lisinopril. On physical examination there was a noticeable difficult time with carriage and gait. Movements were restricted, slow and guarded. She has pain in the forearm, became very upset during the examination, and began crying from movement and palpation. There were positive Waddell's sings present. The cervical examination was normal. The JAMAR grip strength testing, the injured worker could not exert maximal effort with the left hand due to pain and unable to grip 3 times on the left causing her to cry on the third attempt. Sensory testing noted

generalized dysesthesia of the left upper extremity and reduced sensory C5-C6. Phalen and Tinel testing were positive as well as Durkan's test reported as positive all on the left. The left shoulder is Grade 3 tenderness to palpation over the acromioclavicular joint and glenohumeral joint. Hawkin's-Kennedy test, Neer's impingement test were positive and caused the injured worker to cry. There was global weakness of the left shoulder due to moderate to severe pain which prohibited full effort. The injured worker was unable to touch her left thumb to the base of the "pinky" and thumb motion was within normal limits. Thumb abduction was Grade 4 left side. The provider recommended chiropractic care 4 sessions over 4 weeks to the right shoulder and wrist including Codman's shoulder exercises and tendon gliding exercises; TENS unit for home use. He also recommended acupuncture 4 sessions over 4 weeks to the left upper extremity and an MRI of the left shoulder. Pain management was also recommended for medication and possible injections. He also requested authorization of an EMG/NCV of the bilateral upper extremities in hopes she would be able to tolerate the study.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV of the bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints, Chapter 8 Neck and Upper Back Complaints Page(s): 177-178, 261, 309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back Chapter, Electrodiagnostic studies, Electromyography (EMG), Nerve conduction studies (NCS).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260-262. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Electrodiagnostic testing (EMG/NCS).

Decision rationale: ACOEM States "Appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful." ODG states "Recommended needle EMG or NCS, depending on indications. Surface EMG is not recommended. Electromyography (EMG) and Nerve Conduction Studies (NCS) are generally accepted, well-established and widely used for localizing the source of the neurological symptoms and establishing the diagnosis of focal nerve entrapments, such as carpal tunnel syndrome or radiculopathy, which may contribute to or coexist with CRPS II (causalgia), when testing is performed by appropriately trained neurologists or physical medicine and rehabilitation physicians (improperly performed testing by other providers often gives inconclusive results). As CRPS II occurs after partial injury to a nerve, the diagnosis of the initial nerve injury can be made by electrodiagnostic studies." ODG further clarifies "NCS is not recommended, but EMG is recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious." The medical documentation provided

indicates this patient had a left upper extremity injury. The treating physician does not document subjective complaints or objective findings in the right upper extremity that would warrant testing of the bilateral upper extremities. The treating physician has not met the above ACOEM and ODG criteria for an EMG of the upper extremities. As such, the request for EMG/NCV of the bilateral upper extremities is not medically necessary.