

<b>Case Number:</b>	CM15-0108411		
<b>Date Assigned:</b>	06/15/2015	<b>Date of Injury:</b>	04/15/2014
<b>Decision Date:</b>	07/14/2015	<b>UR Denial Date:</b>	05/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/05/2015

### 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: North Carolina  
Certification(s)/Specialty: Family Practice

### 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 53 year old female patient who sustained an industrial injury on 04/15/2014. The accident was described as occurring while he was pushing a heavy cart of rugs and bend his right thumb backwards. A recent primary treating office visit dated 05/07/2015 reported subjective complaint of having right thumb, right hand to elbow pain that is more apparent now the injection benefits have worn off. He is wearing a brace on the right thumb. She is diagnosed with being status post right trigger thumb release on 10/15/2014, and right elbow strain/sprain. The patient is prescribed returning to modified work on 12/05/2014. Of note, consultation recommended electric nerve conduction study awaiting results. A follow up visit on 02/27/2015 showed a plan of care involving recommending a second orthopedic consultation for opinion. She did undergo a course of both physical and chiropractic therapy. Current medication regimen consisted of: Ibuprofen, Norco 7.5mg and Methylprednisone. A therapy re-evaluation on 02/11/2015 reported the patient displaying minimal gains in right grip strength and decreases in wrist and thumb range of motion compared to previous report.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Electromyography/nerve conduction velocity studies of the bilateral upper extremities:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007), Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Elbow Chapter, Tests for cubital tunnel syndrome, Electromyography, Nerve conduction studies.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173-174.

**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, computed 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. There is evidence of neurologic dysfunction on exam. There is no mention of planned invasive procedures. There are no subtle neurologic findings listed on the physical exam. Conservative treatment has not been exhausted. For these reasons criteria for special diagnostic testing has not been met per the ACOEM. Therefore, the request is not medically necessary.