

<b>Case Number:</b>	CM15-0166691		
<b>Date Assigned:</b>	09/11/2015	<b>Date of Injury:</b>	12/28/2010
<b>Decision Date:</b>	10/09/2015	<b>UR Denial Date:</b>	07/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/25/2015

### 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: California, Indiana, New York  
Certification(s)/Specialty: Internal 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 49-year-old female, who sustained an industrial injury on 12-28-10. She reported pain in the left hand and right arm. The injured worker was diagnosed as having status post left hand puncture wound, left elbow sprain or strain, left shoulder sprain or strain, status post arthroscopic subacromial decompression and partial distal claviclectomy, herniated nucleus pulposus at C4-7 with chronic sprain or strain, status post left carpal tunnel release, status post ulnar nerve transfer, and status post right shoulder extensive arthroscopic subacromial decompression and partial distal claviclectomy. Treatment to date has included physical therapy, left shoulder surgery in February 2012, left elbow and left wrist surgery in October 2012, right shoulder surgery in October 2014, and medication. Physical examination findings on 3-25-15 included tenderness to palpation of the neck with spasms and trigger points. Biceps, triceps, and brachioradialis reflexes were normal and sensation was normal. Currently, the injured worker complains of neck aches, right shoulder pain, left shoulder pain, left elbow pain, left wrist pain, and right ankle pain. The treating physician requested authorization for electromyogram and nerve conduction studies 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/NCS of the bilateral upper extremities:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck section, EMG/NCV.

**Decision rationale:** Pursuant to the Official Disability Guidelines, EMG/NCV of the bilateral upper extremities is not medically necessary. The ACOEM states (chapter 8 page 178) unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging 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. Nerve conduction studies are not recommended to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG 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-neuropathies if other diagnoses may be likely based on physical examination. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms because of radiculopathy. While cervical electro diagnostic studies are not necessary to demonstrate his cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality, diabetic property or some problem other than cervical radiculopathy. In this case, the injured worker's working diagnoses are status post left hand puncture wound/laceration with infection healed; left elbow sprain strain; left shoulder sprain strain; status post arthroscopic subacromial decompression and partial distal claviclectomy February 2012; herniated nucleus pulposus C4 - C5, C-5 - C6 and C6 - C7 with chronic sprain strain; right shoulder overuse syndrome, secondary injury; status post carpal tunnel release left; status post ulnar nerve transfer; status post right shoulder extensive arthroscopic subacromial decompression and partial distal claviclectomy. Date of injury is December 28, 2010. There is no request for authorization in the medical record. According to a July 9, 2015 progress note, the injured worker had an EMG/NCV. According to a March 25, 2015 progress note an EMG was performed. The examination was normal. Later in the progress note, the treating provider orders a "repeat NCV". There is no date on the repeat NCV. According to a July 9, 2015 orthopedic reevaluation, the worker's subjective complaints are left shoulder, elbow, hand with numbness and neck pain. Objectively, a sensory examination was performed. There were no other neurologic physical findings noted. The treating provider is requesting a third EMG/NCV. There is no clinical rationale for a third EMG/NCV. There are no unequivocal findings that identify a specific nerve compromise on the neurologic examination sufficient to warrant repeat EMG/NCV. Based on the clinical information in the medical record, peer-reviewed evidence-based guidelines, to prior sets of EMG/NCV, no clinical rationale for a third EMG/NCV, EMG/NCV of the bilateral upper extremities is not medically necessary.