

<b>Case Number:</b>	CM15-0195048		
<b>Date Assigned:</b>	10/08/2015	<b>Date of Injury:</b>	10/05/2011
<b>Decision Date:</b>	11/18/2015	<b>UR Denial Date:</b>	09/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/05/2015

### 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:

This is a 54 year old male with a date of injury of October 5, 2011. A review of the medical records indicates that the injured worker is undergoing treatment for bilateral carpal tunnel syndrome. Medical records dated July 28, 2015 indicate that the injured worker complained of bilateral hand pain rated at a level of 8 out of 10, and bilateral wrist pain. A progress note dated September 17, 2015 documented complaints of bilateral wrist pain rated at a level of 5 to 7 out of 10. Per the treating physician (September 17, 2015), the employee had work restrictions that included limited use of the hands. The physical exam dated July 28, 2015 reveals tenderness to the wrists and hands, end range of motion pain, and positive Phalen's test. The progress note dated September 17, 2015 documented a physical examination that showed similar findings to what was documented in the examination on July 28, 2015 along with new findings of weakness to the right thumb. Treatment has included at least fourteen sessions of hand therapy, at least three sessions of acupuncture, and topical compound creams. The original utilization review (September 25, 2015) partially certified a request for electromyogram-nerve conduction velocity study of the bilateral upper extremities (original request for electromyogram-nerve conduction velocity study and Somatosensory Evoked Potentials study 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:

**NCV, SSEP, EMG of bilateral upper extremities: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies.

**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 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 or subtle physiologic evidence of tissue insult or neurologic dysfunction. 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.