

<b>Case Number:</b>	CM15-0204719		
<b>Date Assigned:</b>	10/21/2015	<b>Date of Injury:</b>	07/01/2015
<b>Decision Date:</b>	12/02/2015	<b>UR Denial Date:</b>	09/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/19/2015

### 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 male, who sustained an industrial injury on 07-01-2015. The injured worker is currently temporarily totally disabled. Medical records indicated that the injured worker is undergoing treatment for bilateral upper extremity overuse syndrome, chronic myofascial pain syndrome, bilateral tri-compartmental arthritis, and bilateral carpal tunnel syndrome. No noted treatments or diagnostics in received medical records. Subjective data (09-03-2015), included bilateral forearm, wrist, and hand pain with numbness in both palms. Objective findings (09-03-2015) included spasms in both upper arms with loss of sensation in both palms, thumbs, and forefingers, positive Phalen's and reverse Phalen's bilaterally, and positive Durkan's and Finkelstein's on the right. The request for authorization dated 09-22-2015 requested MRI of bilateral knees, EMG-NCS (electromyography-nerve conduction velocity studies) of bilateral upper extremities, and Acupuncture. The Utilization Review with a decision date of 09-29-2015 denied the request for EMG-NCS 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:

**Electromyogram (EMG)/Nerve conduction study (NCS) of the bilateral upper extremities:**

Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Biofeedback. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC), Forearm, Wrist, Hand (Acute & Chronic); ODG-TWC Pain (Chronic).

**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 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 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.