

<b>Case Number:</b>	CM15-0209051		
<b>Date Assigned:</b>	10/28/2015	<b>Date of Injury:</b>	05/31/2013
<b>Decision Date:</b>	12/08/2015	<b>UR Denial Date:</b>	10/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/23/2015

### 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 57 year old female sustained an industrial injury on 5-31-13. Documentation indicated that the injured worker was receiving treatment for brachial neuritis and shoulder pain. Previous treatment included carpal tunnel release (11-25-14), physical therapy, injections, bracing and medications. Electromyography and nerve conduction velocity test bilateral upper extremities (3-31-14) showed bilateral carpal tunnel syndrome but no evidence of cervical radiculopathy. In an orthopedic evaluation dated 4-15-15, the injured worker complained of neck pain, right shoulder pain and bilateral wrist pain. The injured worker reported having difficulty lifting, pushing, pulling, twisting and difficulty with self-hygiene and dressing. Physical exam was remarkable for bilateral wrist with decreased range of motion, positive Phalen's and reverse Phalen's and 6mm two point discrimination on the right. In a PR-2 dated 9-16-15, the injured worker complained of ongoing right shoulder and bilateral wrist pain. The injured worker reported getting no relief from recent right shoulder cortisone injection. The injured worker reported that bilateral wrist pain "severely" affected her ability to perform activities of daily living and interfered with sleep. Physical exam was remarkable for right shoulder with positive impingement and Hawkin's sign, 4 out of 5 deltoid muscle strength, pain and guarding on palpation of the right shoulder with "decreased" range of motion and bilateral wrist with positive Phalen's, reverse Phalen's and Tinel's sign, "diminished" grip strength bilateral and two-point discrimination diminished to 6mm to bilateral hands. The treatment plan included electromyography and nerve conduction velocity test of bilateral upper extremities and physical therapy to bilateral wrists. On 10-7-15, Utilization Review non-certified a request for repeat electromyography and nerve conduction velocity test of bilateral upper extremities.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Repeat EMG/NCV of The BUE:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**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. 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.