

<b>Case Number:</b>	CM15-0213654		
<b>Date Assigned:</b>	11/03/2015	<b>Date of Injury:</b>	04/06/2015
<b>Decision Date:</b>	12/15/2015	<b>UR Denial Date:</b>	10/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/30/2015

### 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: Montana, Oregon, Idaho  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 72 year old male, who sustained an industrial injury on 4-6-15. The injured worker was being treated for status post amputation of distal part of left middle finger, pain and numbness of left hand and left arm, rule out trauma of left brachial plexus and causalgia-hyperpathia of stump of left 3rd digit. On 9-9-15 he notes the tip of left middle finger stump is becoming less tender and sensitive and on 10-3-15, the injured worker complains of pain and hypersensitivity to touch of left middle finger stump, constant pain in left hand that radiates into left arm up to left shoulder and varies from 3-8 out of 10 pain scale without medication, decreased sleep and depression due to pain. He complains of numbness and tingling sensation s up to 50% of the time worse in morning and at nighttime and relieved somewhat with medications or ice packs. He is currently not working. Physical exam performed on 10-3-15 revealed status post amputation of distal phalanx of left middle finger, decreased sensation to fine touch and pinprick of 3rd digit of left hand and he is not able to make a full grip with left hand due to amputation of left middle finger. Treatment to date has included surgery to left middle finger stump, 25 sessions of physical therapy and activity modifications. The treatment plan included request for EMG-NCV studies of left hand-arm. On 10-15-15 request for EMG-NCV studies of left hand-arm was non-certified by utilization review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **EMG/NCV study of the left upper extremity: 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), Neck & Upper Back Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) carpal tunnel and neck.

**Decision rationale:** CA MTUS/ACOEM is silent on the issue of EMG/NCV testing. According to the ODG, Carpal tunnel section, "Recommended in patients with clinical signs of CTS who may be candidates for surgery. The ODG neck section states the 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-neuropathic processes if other diagnoses may be likely based on the clinical exam. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy. (Utah, 2006) (Lin, 2013) While cervical electrodiagnostic studies are not necessary to demonstrate a cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality, diabetic neuropathy, or some problem other than a cervical radiculopathy, with caution that these studies can result in unnecessary over treatment. Studies have not shown portable nerve conduction devices to be effective. In this case the injured worker is a 72 year old male who sustained a traumatic amputation of the left distal middle finger. The specific mechanism of injury is not described in the submitted documentation. The records provided do not demonstrate objective evidence of findings consistent with cervical radiculopathy, brachial plexopathy or carpal tunnel syndrome. As the request is not for a reason supported by the cited guidelines, the request is not medically necessary.