Case Number:	CM15-0031181		
Date Assigned:	02/24/2015	**Date of Injury:**	06/01/2010
Decision Date:	04/03/2015	**UR Denial Date:**	01/30/2015
Priority:	Standard	**Application Received:**	02/19/2015

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: 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 51 year old female who sustained a work related injury June 1, 2010, due to repetitive work, with complaints of pain in the upper extremities and left thumb, and later diagnosed as carpal tunnel syndrome. According to an initial office visit with a pain and rehabilitation physician, dated January 15, 2015, the injured worker presented with left great than right upper extremity pain and dysesthesias through the second through fourth digits with persistent numbness in the left thumb and less thumb numbness in the right thumb. There is radiation of pain numbness and tingling in the volar aspect of the forearms bilaterally with aching like sensation in the upper arms and into the cervicobrachial region. Diagnoses are documented as bilateral carpal tunnel syndrome and bilateral cervicobrachial syndrome. Treatment included request for repeat electrodiagnostic studies and topical Lidoderm Patch. Work status is full time with modifications. According to utilization review dated January 30, 2015, the request for EMG (electromyography) of the bilateral upper extremities is non-certified, citing Official Disability Guidelines (ODG) and ACOEM Practice Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG (Electromyogram) of the bilateral Upper Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 261. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Carpal Tunnel Syndrome chapter, Electrodiagnostic studies (EDS) and Nerve Conduction Studies (NCS).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178. 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 on the basis of radiculopathy. While cervical electrodiagnostic 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 bilateral carpal tunnel syndrome; and bilateral cervicobrachial syndrome. The medical record contains 27 pages. The documentation indicates the injured worker had to prior sets of electrodiagnostic studies. The study performed May 17, 2011 was normal. The electrodiagnostic study performed September 28, 2012 show mild carpal tunnel syndrome and no evidence of cervical radiculopathy. The documentation does not contain comparison history and physical examinations to determine whether symptoms progressed since the May 17, 2011 electrodiagnostic study and the September 28, 2012 electrodiagnostic study. There were no significant clinical signs and symptoms in the medical record indicating a third EMG/NCV was medically indicated. The ACOEM states unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging if symptoms persist. There were no unequivocal neurological findings on physical examination present in the medical record identifying specific nerve compromise. Moreover, as noted above, two prior sets of electrodiagnostic studies were performed to date. Consequently, absent clinical documentation with subjective signs and symptoms accompanying the electrodiagnostic studies from May 17, 2011 at September 28, 2012, EMG bilateral upper extremities is not medically necessary.