

<b>Case Number:</b>	CM15-0051255		
<b>Date Assigned:</b>	03/24/2015	<b>Date of Injury:</b>	06/18/2012
<b>Decision Date:</b>	05/13/2015	<b>UR Denial Date:</b>	03/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/18/2015

### 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

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 54-year-old female who reported an injury on 06/18/2012. Her mechanism of injury was not included. Her diagnoses included wrist joint inflammation, chronic regional pain syndrome involving shoulder, elbow, wrist, hand, chronic pain syndrome. Her past treatments have included 24 physical therapy sessions, TENS unit, hot and cold wraps. Her diagnostic studies included electrodiagnostics performed in 2012, MRI of the wrist performed on 02/24/2015, that indicated wrist joint inflammation with TFCC ligament tear, extensor carpi ulnaris tenosynovitis, ganglion cyst along the scapholunate area. TFCC ligament radial tear with medial nerve inflammation. A bone scan that was performed on 05/24/2014 that indicated uptake of activity, increased flow, and blood pool. Her surgical history included a wrist arthroscopy, dated 03/24/2014. The injured worker had complained of persistent pain, numbness, tingling, and swelling. On physical exam, it was noted that injured worker had difficulty with flexion, abduction is no more than 80 degrees with stiffness along the shoulder, exquisite tenderness was noted along the wrist, CMC, first extensor as well as the dorsum of the wrist. She had swelling across the wrist and forearm. She has pain along the elbow as well as the shoulder and stiff shoulder. Her medications included Nalfon, tramadol ER, LidoPro lotion, and Protonix. Her treatment plan included requesting EMG/NCV to determine changes in neurofunction after surgery.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**EMG of left upper extremity:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

**Decision rationale:** The ACOEM Guidelines state that for most patients presenting with true neck or upper back problems, special studies are not needed unless a three or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out. 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. There was a lack of documentation regarding failure of conservative care and lack of documentation of neurological dysfunction on exam. Therefore, the request for EMG of the left upper extremity is not medically necessary.

**NCV of right upper extremity:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

**Decision rationale:** The ACOEM Guidelines state that for most patients presenting with true neck or upper back problems, special studies are not needed unless a three or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out. 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. There was a lack of documentation regarding failure of conservative care and lack of documentation of neurological dysfunction on exam. Therefore, the request for NCV of the right upper extremity is not medically necessary.

**NCV of left upper extremity:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

**Decision rationale:** The ACOEM Guidelines state that for most patients presenting with true neck or upper back problems, special studies are not needed unless a three or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out. 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. There was a lack of documentation regarding failure of conservative care and lack of documentation of neurological dysfunction on exam. Therefore, the request for NCV of the left upper extremity is not medically necessary.

**EMG of right upper extremity:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

**Decision rationale:** The ACOEM Guidelines state that for most patients presenting with true neck or upper back problems, special studies are not needed unless a three or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out. 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. There was a lack of documentation regarding failure of conservative care and lack of documentation of neurological dysfunction on exam. Therefore, the request for EMG of the right upper extremity is not medically necessary.