

<b>Case Number:</b>	CM15-0089700		
<b>Date Assigned:</b>	05/14/2015	<b>Date of Injury:</b>	11/12/2012
<b>Decision Date:</b>	06/15/2015	<b>UR Denial Date:</b>	04/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/11/2015

### 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 is a 63 year old male with a November 12, 2012 date of injury. A progress note dated February 26, 2015 documents subjective findings (follow up evaluation for the cervical spine and upper extremities; no new symptoms or changes other than the same weakness of the fingers of the left hand; last two fingers of the left hand not as functional as the other fingers), objective findings (no pain on palpation of the cervical paraspinal and trapezial musculature; decreased range of motion of the cervical spine; Tinel's sign positive for some numbness and tingling and pain down the left elbow and forearm; Tinel's is positive in the right wrist for some numbness and tingling in the fingers of the right hand; muscle atrophy of the left hand; decreased strength of the left hand), and current diagnoses (chronic persistent axial neck pain; significant numbness in the thumb, index finger and middle finger; significant atrophy in the left thenar pad as well as hypothenar eminence; left carpal tunnel syndrome; left cubital tunnel syndrome). Treatments to date have included medications, magnetic resonance imaging of the cervical spine (May 5, 2014; showed severe canal stenosis as well as foraminal stenosis), left carpal tunnel surgery, left thumb reconstruction, and physical therapy. The treating physician notes concern for double crush syndrome due to the injured worker's symptoms involving the left hand. The treating physician documented a plan of care that included EMG of the right upper extremity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **Electromyogram (EMG) of the 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 Page(s): 178, 269.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173-174.

**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, compute 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 temporarily 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.