

<b>Case Number:</b>	CM14-0028138		
<b>Date Assigned:</b>	06/13/2014	<b>Date of Injury:</b>	09/19/2007
<b>Decision Date:</b>	09/24/2014	<b>UR Denial Date:</b>	02/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/05/2014

### 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. The expert reviewer is Board Certified in Internal Medicine and is licensed to practice in Arizona. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 claimant is a 30-year-old female who worked as a customer service representative for approximately 4 years. She has an official date of injury September 19, 2007. Over time she had a progression of symptoms of pain in wrists, elbows and shoulders. She failed splints, medications, physical therapy, and extracorporeal shock wave therapy. An October 1, 2009 EMG/NCV electrodiagnostic studies revealed bilateral severe median nerve neuropathy and mild ulnar neuropathy at both elbows. She's had a progression of symptoms and now complains of worsening shoulder and neck pain. A March 24, 2014 x-ray of the cervical spine (report is not in the record) was stated to show evidence of a fracture or dislocation or gross bony abnormality and it was recommended that she undergo more current electrodiagnostic studies and a cervical MRI. The EMG/NCV was not found to be medically necessary, because the 2009 electrodiagnostic studies already showed bilateral Carpal Tunnel Syndrome and mild ulnar compression at the elbows. The purpose of this Outside Medical Review is to determine if repeat electrodiagnostic studies are warranted of the right upper extremities at this point in time. The physician who ordered the current EMG/NCV studies claimed they were necessary because the patient had additional symptoms from the neck and it was important to clarify her overall pathology.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 EMG OF THE RIGHT UPPER EXTREMITY:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 261.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

**Decision rationale:** A 2009 EMG/NCV evaluation indicated the patient had severe carpal tunnel syndrome and mild ulnar neuropathy. The physician is currently trying to evaluate the neck, in light of her worsening neck and shoulder complaints and the abnormal neck x-ray. He wants to obtain an EMG/ NCV and MRI of the neck to clarify any contribution of the neck to the patients overall symptomatology of hand, wrist and shoulder pain. The MTUS states: 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 a 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 any 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 3 or 4 weeks. The assessment may include sensory evoked potentials (SEP's) if spinal stenosis or spinal cord myelopathy is suspected. If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with the consultant regarding next steps, including the selection of an imaging test to define a potential cause (MRI for neural or soft tissue, CT for bony structures). Additional studies may be considered to further define problem areas. I agree that the diagnoses for Carpal Tunnel Syndrome and Ulnar neuropathy are already known from an old EMG/NCV. It is reasonable to repeat the studies to clarify any contribution the neck might have to the overall picture, especially in light of the desire of the physician to also obtain a neck MRI. A new electrodiagnostic evaluation could reveal no cervical compression and thus declare a cervical MRI not medically indicated. Conversely, it could confirm cervical compression warranting further testing with appropriate imaging. An added benefit to obtaining a current EMG is to assess for the progression of the ulnar nerve compression. The complainant's symptoms in the 4th and 5th digits could represent an uncommon C8 nerve root versus ulnar nerve compression. The shoulder symptoms could represent a C4 or C5 nerve root compression. Surgery was not discussed in the medical records, but can be a solution to severe compressive symptoms such as for her Carpal Tunnel Syndrome. Before there is any discussion of decompressive surgery it is necessary to get a clear picture of the patient's nerve dysfunctions including cervical. Thus, it is deemed that a right sided upper extremity EMG is medically necessary.

**1 NCV OF THE RIGHT UPPER EXTREMITY:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 261.

**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, Nerve conduction studies (NCS).

**Decision rationale:** See the above justification for obtaining electrodiagnostic testing to include any cervical compression. The ODG, guidelines for Nerve Conduction Studies (NCS) states: "NCS is 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. " If the EMG for this claimant does not confirm a cervical compression as a cause of the patient's neck and shoulder symptoms, a Nerve Conduction Study is warranted. The ODG guidelines further states: It is appropriate for only 1 attending physician to perform or supervise all of the components of the electrodiagnostic testing (e.g., history taking, physical evaluation, supervision and/or performance of the electrodiagnostic test, and interpretation) for a given patient and for all the testing to occur on the same date of service. The reporting of NCS and EMG study results should be integrated into a unifying diagnostic impression." Thus, it is not appropriate to obtain an EMG and if negative, obtain an NCV at a later date. Thus, it is deemed medically necessary to obtain a Right upper extremity NCV along with the above recommended EMG.