

<b>Case Number:</b>	CM15-0126602		
<b>Date Assigned:</b>	07/13/2015	<b>Date of Injury:</b>	08/09/2013
<b>Decision Date:</b>	08/06/2015	<b>UR Denial Date:</b>	06/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/30/2015

### 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: 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 49 year old male, who sustained an industrial injury on September 9, 2013. The injured worker reported fall resulting in right wrist fracture. The injured worker was diagnosed as having radius fracture, right shoulder, right elbow, right knee and lumbar strain/sprain right shoulder impingement, lateral epicondylitis and herniated lumbar disc. Treatment to date has included medication and magnetic resonance imaging (MRI). A progress note dated May 14, 2015 provides the injured worker complains of right shoulder, wrist and knee pain. Physical exam notes cervical exam notes tenderness on palpation with spasm and positive foraminal compression and Spurling's test. There is right shoulder tenderness with decreased range of motion (ROM), positive impingement, subacromial grinding and clicking and rotator cuff tenderness. There is lumbar tenderness with decreased range of motion (ROM) and positive bilateral straight leg raise. The plan includes injection, electromyogram, nerve conduction study, Motrin, Prilosec, Ultram and follow-up.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**EMG/NCV of The BUE:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): Neck & Upper Back, Special Studies and Diagnostic and Treatment Considerations, pages 177-178.

**Decision rationale:** Review indicates the patient has a recent EMG/NCS of BUE on 2/24/15 showing median entrapment at the wrist without evidence for cervical radiculopathy. The patient has established diagnosis of CTS by previous EMG/NCV and continues to treat without functional benefit. Additionally, per MTUS Guidelines, without specific symptoms or neurological compromise consistent with radiculopathy, foraminal or spinal stenosis, medical necessity for EMG has not been established. Current submitted reports have not adequately demonstrated any change in chronic symptoms and clinical findings of neurological deficits suggestive of deterioration. There are also no identified new injuries, acute flare-up or red-flag conditions with changed chronic symptoms and clinical findings to support repeating the electrodiagnostic study. The EMG/NCV of The BUE is not medically necessary or appropriate.