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| **Case Number:** | CM15-0067052 | | |
| **Date Assigned:** | 04/14/2015 | **Date of Injury:** | 12/05/2012 |
| **Decision Date:** | 05/19/2015 | **UR Denial Date:** | 04/03/2015 |
| **Priority:** | Standard | **Application Received:** | 04/08/2015 |

## 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: Arizona, Texas
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 46 year old male who sustained an industrial injury on 12/05/2012. Current diagnoses include cervicalgia, right shoulder post-traumatic osteoarthritis/rotator cuff partial tear/superseding frozen shoulder and adhesive capsulitis, right neurogenic thoracic outlet syndrome, right carpal tunnel syndrome, and opioid dependence. Previous treatments included medication management, right shoulder surgery, physical therapy, and home exercises. Previous diagnostic studies included an x-rays, MRI's and EMG/NCV study. Initial complaints included head, neck, right shoulder, right arm, right elbow, right wrist, and right hand and fingers injuries after slipping and falling. Report dated 02/02/2015 noted that the injured worker presented with complaints that included pain in the head, neck, upper back, right shoulder, right wrist and hand with radiation to the right arm with associated numbness and tingling. Pain level was rated as 7 out of 10 (average) on the visual analog scale (VAS). Physical examination was positive for abnormal findings. The treatment plan included request for EMG/NCV study to rule out cervical radiculopathy, request for an MRI of the cervical spine, request for a diagnostic right suprascapular nerve injection, request for right brachial plexus MR neurography, continue with Vicodin, medication requests, request for physical therapy, and follow up in 4 weeks. Disputed treatments include EMG (electromyography)/NCV (nerve conduction velocity) of the bilateral upper extremities.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**EMG (electromyography)/NCV (nerve conduction velocity) of:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Carpal Tunnel Syndrome, EMG/NCV.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178-179.

**Decision rationale:** Nerve conduction study (NCS) techniques permit stimulation and recording of electrical activity from individual peripheral nerves with sufficient accuracy, reproducibility, and standardization to determine normal values, characterize abnormal findings, and correlate neurophysiologic-pathologic features. These clinical studies are used to diagnose focal and generalized disorders of peripheral nerves, aid in the differentiation of primary nerve and muscle disorders (although NCS itself evaluates nerve and not muscle), classify peripheral nerve conduction abnormalities due to axonal degeneration, demyelination, and conduction block and prognosticate regarding clinical course and efficacy of treatment. NCS should not be performed or interpreted as an isolated diagnostic study. Instead, it should be performed and interpreted at the same time as an EMG. When definitive neurologic findings on physical exam, electrodiagnostic studies, lab tests, or bone scans are present imaging may be warranted. 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), may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. In this case, the requested studies are for the upper extremities. The IW has had previous EMG/NCS showing severe right sided carpal tunnel syndrome. The patient is to have a cervical spine MRI. The EMG/NCS are not medically necessary as the patient has had a previous study and imaging of the cervical spine will evaluate for any neurological compromise.