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| **Case Number:** | CM15-0073053 | | |
| **Date Assigned:** | 04/23/2015 | **Date of Injury:** | 03/18/2011 |
| **Decision Date:** | 06/10/2015 | **UR Denial Date:** | 04/14/2015 |
| **Priority:** | Standard | **Application Received:** | 04/17/2015 |

## 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: New Jersey, Alabama, California
Certification(s)/Specialty: Neurology, Neuromuscular 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 78 year old female, who sustained an industrial injury on 03/18/2011. According to a progress report dated 03/31/2015, the injured worker presented with bilateral hand pain. She underwent a right carpal tunnel release in July 2012 that was followed by worsening symptoms. She did not complain of numbness or tingling to the right hand. She complained of more pain and difficulties in the right hand and thumb. Symptoms on the right side had plateaued and she was not interested in further intervention on this side. Previous treatments also included cortisone injections for the right hand. Nerve Conduction studies in 2011 confirmed severe right carpal tunnel syndrome, moderately severe on the left. Symptoms of the left hand were similar and had been progressively worsening over the years. She had occasional numbness and tingling, but her symptoms were more relatable to a radiating or burning type pain to the thumb. She denied night time symptoms with awakening at night. She tried night time bracing which had not alleviated the symptoms. Physical examination demonstrated full and normal range of motion of the bilateral wrists with normal strength and stability. There was mild tenderness over the thumb carpometacarpal with positive grind test. There was positive Tinel's on the right and a positive modified Phalen's compression test on the right with reproduction of symptoms. There was a negative Tinel's on the left and a positive modified Phalen's compression test on the left. There was mild tenderness about the thumb carpometacarpal and a positive grind test. Assessment included left carpal tunnel syndrome, right carpal tunnel syndrome and bilateral thumb carpal metacarpal arthritis. Treatment plan

included Nerve Conduction Velocity studies. Currently under review is the request for Nerve Conduction studies 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:

**NCS bilateral upper extremities:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 269.

**Decision rationale:** According to MTUS guidelines (MTUS page 303 from ACOEM guidelines), "Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks". EMG has excellent ability to identify abnormalities related to disc protrusion (MTUS page 304 from ACOEM guidelines). According to MTUS guidelines, needle EMG study helps identify subtle neurological focal dysfunction in patients with neck and arm symptoms. "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". (Page 178) EMG is indicated to clarify nerve dysfunction in case of suspected disc herniation (page 182). EMG is useful to identify physiological insult and anatomical defect in case of neck pain (page 179). There is no documentation of peripheral nerve damage, cervical radiculopathy and entrapment neuropathy that requires electrodiagnostic testing. There is no documentation of significant change in the patient's condition. Therefore, the request for NCS BUE is not medically necessary.