Case Number:	CM15-0073432		
Date Assigned:	04/23/2015	**Date of Injury:**	11/12/2012
Decision Date:	05/20/2015	**UR Denial Date:**	03/17/2015
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: 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:

The injured worker is a 63 year old male who sustained an industrial injury on 11/12/2012. Diagnoses include chronic persistent axial neck pain, with significant numbness in the thumb, index finger and middle finger, severe canal stenosis as well as foraminal stenosis left side C6-C7 as well as moderate to severe left C5-C6 foraminal stenosis and mild foraminal stenosis at C4-5 per Magnetic Resonance Imaging done 05/05/2014, atrophy in the left thenar pad as well as hypothenar eminence; however, the thenar pad most likely secondary to C6/C7 nerve root compression, and status post left cubital tunnel and left carpal tunnel and left thumb reconstruction done 10/03/2013 with residual difficulty with movement of the index finger, right finger and small finger, with significant weakness in those digits as well as persistent thumb, index finger, and middle finger nonfunctioning as well as numbness, most likely carpal tunnel-related and/or possible cervical spine related. Treatment to date has included diagnostic studies, status post ulnar decompression and left carpal tunnel, and left thumb reconstruction surgery on 10/03/2013, medications, steroid injections, physical therapy, and home exercise program. A physician progress note dated 02/26/2015 documents the injured worker is seen for a follow up evaluation on his cervical spine and upper extremities. He has continued weakness of the fingers of his left hand. He has muscle atrophy of his left hand. He also states his last 2 fingers are not as functional as the other fingers on his left hand. On examination, Tinel's sign is positive for some numbness and tingling and pain down the left elbow and down the forearm. Tinel's is positive in the right wrist for some numbness and tingling in the fingers of his right hand. There is left hypothenar muscle atrophy, no atrophy in the right hand. The treatment plan

is for Electromyography and Nerve Conduction Velocity of the upper extremities. Treatment requested is for 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:

EMG of the right upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

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 neuralor other soft tissue, computer 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 temporally or anatomically with symptoms. The provided documentation does not show signs of emergence of red flags but 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.