

Case Number:	CM13-0036133		
Date Assigned:	12/13/2013	Date of Injury:	07/20/2009
Decision Date:	03/14/2014	UR Denial Date:	10/08/2013
Priority:	Standard	Application Received:	10/18/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Pain Management, has a subspecialty in Disability Evaluation and is licensed to practice in California. 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 physician 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:

The patient is 42 year old female diagnosed with cubital tunnel syndrome, cervical radiculitis, and rule out carpal tunnel syndrome with date of injury 07/20/09. On 5/20/12 she had right carpal tunnel release surgery and still has pain. The pain was sharp shooting, involving the right hand and right forearm and right elbow, with similar symptoms on the left side although less severe. She also reported numbness and tingling involving right little and ring fingers. She subsequently had an EMG/NCV done on 11/16/12 which was interpreted as moderate bilateral slowing involving the median nerves at or near the carpal tunnel (slightly greater on the right side), cubital tunnel syndrome (greater on the right), and acute and chronic cervical radiculopathy involving the C5-C6 level (greater on the left). EMG of the upper extremities also showed acute and chronic cervical radiculopathy involving C5-C6 greater on the left; with electrical abnormalities, denervative in character involving what appears to be the median nerve distribution greater on the right, possibly related to carpal tunnel syndrome. She had a CT-scan of the right wrist taken on 9/20/13 which showed no evidence of a scaphoid cyst. Due to possible nerve compression syndrome, right and left upper extremities, and tendonitis/tenosynovitis involving bilateral upper extremities, a request was made for EMG/NCV of the bilateral upper extremities. The issue(s) are whether EMG of right upper extremity, EMG of left upper extremity, NCV of right upper extremity, NCV of left upper extremity are medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG of left upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 8 Neck and Upper Back Complaints, Chapter 10 Elbow Disorders (Revised 2007), Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 272. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back, Carpal Tunnel Syndrome.

Decision rationale: There are situations in which both electromyography and nerve conduction studies need to be accomplished, such as when defining whether neuropathy is of demyelinating or axonal type. Seldom is it required that both studies be accomplished in straightforward condition of median and ulnar neuropathies or peroneal nerve compression neuropathies. Electromyographic examinations should be done by physicians. (Utah, 2006) A surface EMG is not recommended. The patient had an EMG/NCS of the left upper extremity on 11/16/12, therefore, the added benefit of a another EMG study in the management of the patient who is already known to have cervical radiculopathy, cubital tunnel syndrome, and-bilateral slowing involving the median nerves at or near the carpal tunnel (slightly greater on the right side) diagnosed with a previous EMG/NCS study is not medically necessary.

NCV of right upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 10 Elbow Disorders (Revised 2007), Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 272. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back, Carpal Tunnel Syndrome.

Decision rationale: The ODG chapter on Carpal Tunnel Syndrome (Acute and Chronic) states that Nerve conduction studies (NCS) is recommended in patients with clinical signs of Carpal Tunnel Syndrome (CTS) who may be candidates for surgery. Appropriate electrodiagnostic studies (EDS) include nerve conduction studies (NCS). Carpal tunnel syndrome must be proven by positive findings on clinical examination and should be supported by nerve conduction tests before surgery is undertaken. Mild CTS with normal electrodiagnostic studies (EDS) exists, but moderate or severe CTS with normal EDS is very rare. A positive EDS in asymptomatic individuals is not CTS. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Nerve conduction studies should be done by a qualified technician working directly under the supervision of a physician. (Utah, 2006). The patient had an EMG/NCS of the right upper extremity on 11/16/12, therefore, the added benefit of a another EMG study in the management of the patient who is already known to have cervical radiculopathy, cubital tunnel syndrome, and-bilateral slowing involving the median nerves at or near the carpal tunnel (slightly greater on the right side) diagnosed with a previous EMG/NCS study is not medically necessary.

NCV of left upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 10 Elbow Disorders (Revised 2007), Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 272. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back, Carpal Tunnel Syndrome.

Decision rationale: The ODG chapter on Carpal Tunnel Syndrome (Acute and Chronic) states that Nerve conduction studies (NCS) is recommended in patients with clinical signs of Carpal Tunnel Syndrome (CTS) who may be candidates for surgery. Appropriate electrodiagnostic studies (EDS) include nerve conduction studies (NCS). Carpal tunnel syndrome must be proven by positive findings on clinical examination and should be supported by nerve conduction tests before surgery is undertaken. Mild CTS with normal electrodiagnostic studies (EDS) exists, but moderate or severe CTS with normal EDS is very rare. A positive EDS in asymptomatic individuals is not CTS. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Nerve conduction studies should be done by a qualified technician working directly under the supervision of a physician. (Utah, 2006). The patient had an EMG/NCS of the left upper extremity on 11/16/12, therefore, the added benefit of a another EMG study in the management of the patient who is already known to have cervical radiculopathy, cubital tunnel syndrome, and-bilateral slowing involving the median nerves at or near the carpal tunnel (slightly greater on the right side) diagnosed with a previous EMG/NCS study is not medically necessary.

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Decision rationale: The ODG chapter on Carpal Tunnel Syndrome (Acute and Chronic) states that Nerve conduction studies (NCS) is recommended in patients with clinical signs of Carpal Tunnel Syndrome (CTS) who may be candidates for surgery. Appropriate electrodiagnostic studies (EDS) include nerve conduction studies (NCS). Carpal tunnel syndrome must be proven by positive findings on clinical examination and should be supported by nerve conduction tests before surgery is undertaken. Mild CTS with normal electrodiagnostic studies (EDS) exists, but moderate or severe CTS with normal EDS is very rare. A positive EDS in asymptomatic individuals is not CTS. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Nerve conduction studies should be done by a qualified technician working directly under the supervision of a

physician. (Utah, 2006). The patient had an EMG/NCS of the right upper extremity on 11/16/12, therefore, the added benefit of a another EMG study in the management of the patient who is already known to have cervical radiculopathy, cubital tunnel syndrome, and-bilateral slowing involving the median nerves at or near the carpal tunnel (slightly greater on the right side) diagnosed with a previous EMG/NCS study is not medically necessary.