

<b>Case Number:</b>	CM13-0037724		
<b>Date Assigned:</b>	12/18/2013	<b>Date of Injury:</b>	06/30/2011
<b>Decision Date:</b>	04/30/2014	<b>UR Denial Date:</b>	09/25/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/01/2013

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Sports Medicine and is licensed to practice in Texas. 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/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 a 43-year-old female who reported injury on 06/30/2011. The mechanism of injury was not provided. The patient had a prior electromyography/nerve conduction velocity (EMG/NCV) per documentation on 03/01/2012, which revealed a normal electrodiagnostic study with no nerve conduction study (NCS) evidence suggestive of a right median sensory or motor neuropathy and no NCS evidence suggestive over right ulnar sensory or motor neuropathy. The patient had a left elbow ulnar nerve transposition in 07/2008. The documentation of 09/17/2013 revealed the patient additionally underwent a right shoulder arthroscopy on 03/15/2013 for subacromial decompression and a distal clavicle resection. The patient was noted to be working on a home exercise program. The patient indicated that she had increased right elbow pain at the medial aspect of her elbow associated with numbness and tingling, which radiates to the patient's ring and little fingers. The patient noted some limited symptoms in the left elbow. The patient reported increased stiffness and cramping in both hands. The physical examination revealed in the right elbow that there was no tenderness to the lateral epicondyle of the common extensor tendon or olecranon or antecubital fossa. There was mild plus tenderness to the medial epicondyle and moderate tenderness over the ulnar nerve in the cubital tunnel associated with a positive Tinel's sign. The first dorsal interosseous muscle demonstrated moderate grade 4 weakness. On the left elbow the patient had minimal tenderness to the medial epicondyle and no tenderness over the transposed ulnar nerve. The first dorsal interosseous muscle demonstrated grade 5 strength. An examination of the bilateral wrists revealed no tenderness in any location, the Finkelstein's test was negative and the patient could make a fist and extend her fingers fully without difficulty. The patient's diagnoses included a right cubital tunnel syndrome associated with medial epicondylitis and a left cubital tunnel syndrome associated with medial epicondylitis status post surgery. The request was made for an EMG/NCV of the bilateral extremities.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **ELECTROMYOGRAPHY (EMG) OF THE BILATERAL UPPER EXTREMITIES:**

Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 261. Decision based on Non-MTUS Citation Electrodiagnostic testing (EMG/NCS).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

**Decision rationale:** The MTUS/ACOEM Guidelines indicate that 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 (3) or four (4) weeks. It was suggested that the patient would probably decide to proceed with the right ulnar nerve neurolysis although the physician would unlikely recommend an ulnar nerve transposition, which would make the right elbow surgery much easier. Additionally, it was noted to further objectify documentation of the cubital tunnel syndrome, even though the patient had cubital tunnel surgery on the left elbow, there was a request for an EMG and NCV of the upper extremities. The physical examination findings as of 01/14/2013 when compared to the examination of 09/17/2013 demonstrated similar findings in the bilateral elbows. There was a lack of documentation indicating a necessity for a repeat study. The original study was not provided for review. There was a lack of documentation of recent conservative care to support the necessity for the study. There was a lack of documentation indicating the necessity for both an EMG and NCV. Given the above, the request for an EMG of the bilateral upper extremities is not medically necessary.

### **NERVE CONDUCTION VELOCITY (NCV) OF THE BILATERAL UPPER EXTREMITIES:**

Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 261. Decision based on Non-MTUS Citation Electrodiagnostic testing (EMG/NCS).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

**Decision rationale:** The MTUS/ACOEM Guidelines indicate that 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 (3) or four (4) weeks. It was suggested that the patient would probably decide to proceed with the right ulnar nerve neurolysis although the physician would unlikely recommend an ulnar nerve transposition, which would make the right elbow surgery much easier. Additionally, it was noted

to further objectify documentation of the cubital tunnel syndrome, even though the patient had cubital tunnel surgery on the left elbow, there was a request for an EMG and NCV of the upper extremities. The physical examination findings as of 01/14/2013 when compared to the examination of 09/17/2013 demonstrated similar findings in the bilateral elbows. There was a lack of documentation indicating a necessity for a repeat study. The original study was not provided for review. There was a lack of documentation of recent conservative care to support the necessity for the study. There was a lack of documentation indicating the necessity for both an EMG and NCV. Given the above, the request for an NCV of the bilateral upper extremities is not medically necessary.