

Case Number:	CM13-0071924		
Date Assigned:	01/08/2014	Date of Injury:	10/18/2011
Decision Date:	05/27/2014	UR Denial Date:	12/09/2013
Priority:	Standard	Application Received:	12/30/2013

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 Family Practice and is licensed to practice in New Jersey. 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 worker is a 60-year-old male who injured his right wrist on 10/18/2011, and was later diagnosed with carpal tunnel syndrome. He went through physical and occupational therapy for the right wrist followed by a carpal tunnel release of the right wrist, which was performed on 9/6/12. Later when examined by a treating physician on 2/28/13, the treating physician examined the right wrist and found that the neurovascular exam was slightly abnormal, noting that there was a positive Tinel's sign at the cubital tunnel. Later on 10/30/13, the worker was re-examined by the treating physician, but this time complained of progressively worsening symptoms in the ring and small finger of the right hand. The physical examination on this date showed a positive Tinel's sign, positive elbow flexion test with paresthesia extending to the small fingers, but with normal strength testing, which led to a diagnosis of ulner nerve impingement with right cubital tunnel syndrome. The worker was then ordered an electromyogram (EMG) on this same date by his treating physician as well as a nerve conduction velocity study (NCV). The treating physician did not order any specific conservative treatment method for the elbow in either of these two (2) office visits, according to the progress notes provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

ELECTROMYOGRAM (EMG) OF THE RIGHT UPPER EXTREMITY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 177-178,261.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 15,18-19. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), SURGERY FOR CUBITAL TUNNEL SYNDROME (ULNAR NERVE ENTRAPMENT) SECTION, LESION OF ULNAR NERVE PHYSICAL THERAPY GUIDELINES.

Decision rationale: The MTUS/ACOEM Guidelines discusses ulnar nerve entrapment and cubital tunnel syndrome and suggests that although the evidence is limited, the following methods may be considered as part of conservative care for these conditions: 1. elbow padding; 2. avoidance of leaning on the ulnar nerve; 3. Avoidance of prolonged hyperflexion of the elbow; and 4. NSAID use (although not particularly successful for neuropathic pain). The Official Disability Guidelines indicate that conservative treatment also consists of exercise that includes strengthening of the elbow flexors/extensors isometrically and isotonicly within 0-45 degrees, which may be in the form of physical therapy (PT) (up to 3 visits per week, with fading to 1 or less per week and 14 visits total over 6 weeks plus active self-directed home PT). The treatments of uncertain effectiveness that are free of undue risk and individual and aggregate cost, a therapeutic trial may be appropriate if side effects and effectiveness are carefully followed. The effectiveness of such a trial should be measured by objective findings appropriate for the patient and the intervention, and should be documented accordingly. The trial should be promptly discontinued if it does not result in subjective or functional improvement. If symptoms persist after conservative treatment beyond four to six (4-6) weeks, referral and other testing may be useful. The ACOEM Guidelines also indicate that the use of electromyogram (EMG) and nerve conduction velocity (ECV) studies may be considered only in the following situations: 1. EMG if cervical radiculopathy is suspected as a cause of lateral arm pain, and that condition has been present for at least six (6) weeks, or 2. Nerve conduction velocity (NCV) and possibly EMG if severe nerve entrapment is suspected on the basis of physical examination, denervation atrophy is likely, and there is a failure to respond to conservative treatment. In the case of this worker, there was no red flag signs, no sign of cervical radiculopathy on examination, nor were there signs of atrophy or weakness on examination by the treating physician; however, there was signs of entrapment of the ulnar nerve on examination, according to the progress notes provided. But in this case the worker was not recommended, nor did he go through any conservative treatment such as physical therapy, splints, pads, non-steroidal anti-inflammatory drugs (NSAIDs), or activity modification, at least according to the records provided, and no record was found of the worker failing these conservative treatments to be able to consider these tests in the first place. Therefore the EMG test, is not medically necessary.

NERVE CONDUCTION VELOCITY (NCV) STUDY OF THE RIGHT UPPER EXTREMITY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 177-178,261.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 15,18-19. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), SURGERY FOR CUBITAL TUNNEL SYNDROME (ULNAR NERVE ENTRAPMENT) SECTION, LESION OF ULNAR NERVE PHYSICAL THERAPY GUIDELINES.

Decision rationale: The MTUS/ACOEM Guidelines discusses ulnar nerve entrapment and cubital tunnel syndrome and suggests that although the evidence is limited, the following methods may be considered as part of conservative care for these conditions: 1. elbow padding; 2. avoidance of leaning on the ulnar nerve; 3. Avoidance of prolonged hyperflexion of the elbow; and 4. NSAID use (although not particularly successful for neuropathic pain). The Official Disability Guidelines indicate that conservative treatment also consists of exercise that includes strengthening of the elbow flexors/extensors isometrically and isotonicly within 0-45 degrees, which may be in the form of physical therapy (PT) (up to 3 visits per week, with fading to 1 or less per week and 14 visits total over 6 weeks plus active self-directed home PT). The treatments of uncertain effectiveness that are free of undue risk and individual and aggregate cost, a therapeutic trial may be appropriate if side effects and effectiveness are carefully followed. The effectiveness of such a trial should be measured by objective findings appropriate for the patient and the intervention, and should be documented accordingly. The trial should be promptly discontinued if it does not result in subjective or functional improvement. If symptoms persist after conservative treatment beyond four to six (4-6) weeks, referral and other testing may be useful. The ACOEM Guidelines also indicate that the use of electromyogram (EMG) and nerve conduction velocity (ECV) studies may be considered only in the following situations: 1. EMG if cervical radiculopathy is suspected as a cause of lateral arm pain, and that condition has been present for at least six (6) weeks, or 2. Nerve conduction velocity (NCV) and possibly EMG if severe nerve entrapment is suspected on the basis of physical examination, denervation atrophy is likely, and there is a failure to respond to conservative treatment. In the case of this worker, there was no red flag signs, no sign of cervical radiculopathy on examination, nor were there signs of atrophy or weakness on examination by the treating physician; however, there was signs of entrapment of the ulnar nerve on examination, according to the progress notes provided. But in this case the worker was not recommended, nor did he go through any conservative treatment such as physical therapy, splints, pads, non-steroidal anti-inflammatory drugs (NSAIDs), or activity modification, at least according to the records provided, and no record was found of the worker failing these conservative treatments to be able to consider these tests in the first place. Therefore the NCV test, is not medically necessary.