

<b>Case Number:</b>	CM14-0153681		
<b>Date Assigned:</b>	09/23/2014	<b>Date of Injury:</b>	08/19/2013
<b>Decision Date:</b>	10/24/2014	<b>UR Denial Date:</b>	09/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/19/2014

### 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 Orthopedic Surgery, 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 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:

This 37-year-old male sustained an industrial injury on 8/19/13. The mechanism of injury was not documented. He was diagnosed with biceps tendon rupture, status post repair, and right carpal tunnel syndrome. The patient was status post right elbow distal biceps repair and lateral antebrachial cutaneous neuroplasty on 3/27/14. Records indicated continued numbness and tingling in the ring and little finger in the post-op period. The patient attended physical therapy, was performing a home exercise program, and used a posterior night splint. The 8/21/14 treating physician report cited on-going discomfort in his right elbow and upper arm. Pain was reported as intermittent aching, dull, and sharp. The main complaint was numbness, tingling, and weakness throughout the right arm, especially involving his ring and little finger. He had been wearing a posterior night splint which was not effective. Physical exam documented decreased right arm swing, good biceps strength with some weakness, and positive Tinel's over the cubital tunnel. He did not have full flexion, extension or supination actively. There was mild loss of passive range of motion. There was no right wrist or hand intrinsic or thenar atrophy. Tinel's and Phalen's were negative at the carpal tunnel. The patient had continued symptoms of cubital tunnel syndrome/ulnar neuropathy at the right elbow and had not responded to conservative treatment. Upper extremity electrodiagnostic study was requested. The 9/15/14 utilization review decision denied the request for right upper extremity EMG based on no evidence of radiculopathy or myelopathy to support the medical necessity of EMG instead of nerve conduction studies. The 9/15/14 treating physician peer-to-peer documentation cited persistent right elbow symptoms for the past several months. Conservative treatment included splints, home exercise program, therapy, and anti-inflammatories. The patient needed electrodiagnostic studies, not specifically EMG, to rule-out ulnar neuropathy/cubital tunnel syndrome.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Electromyography of the right upper extremity:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment in Workers Compensation (TWC), Online edition, chapter; Elbow (Acute and Chronic)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 33-34.

**Decision rationale:** The California MTUS guidelines support EMG in upper extremity complaints if cervical radiculopathy is suspected as a cause of lateral arm pain and that condition has been present for at least 6 weeks. Upper extremity nerve conduction study, and possibly EMG, is recommended in patients with elbow complaints 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. Guideline criteria have not been met. There is no current evidence that cervical radiculopathy is suspected as a cause of this patient's elbow complaints. EMG is not supported in the absence of a nerve conduction study. There is no compelling reason to support the medical necessity of EMG instead of, or in the absence of, a nerve conduction study for the current diagnosis. Therefore, this request is not medically necessary.