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| **Case Number:** | CM14-0175312 | | |
| **Date Assigned:** | 10/28/2014 | **Date of Injury:** | 12/24/2012 |
| **Decision Date:** | 12/04/2014 | **UR Denial Date:** | 10/13/2014 |
| **Priority:** | Standard | **Application Received:** | 10/23/2014 |

## 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 Occupational Medicine, 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:

The applicant is a represented [redacted] employee who has filed a claim for chronic elbow and forearm pain reportedly associated with an industrial injury of December 24, 2012. Thus far, the applicant has been treated with the following: Analgesic medications; unspecified amounts of physical therapy; and earlier left radius open reduction and internal fixation surgery. In a Utilization Review Report dated September 19, 2014, the claims administrator denied a request for MRI imaging of the left elbow and apparently partially approved an EMG-NCS of the left upper extremity as an NCS of the left upper extremity alone.The applicant's attorney subsequently appealed. In an applicant questionnaire dated April 22, 2014, the applicant reported 2/10 pain complaints with associated sensations of numbness and tingling. The applicant was using medications for hypertension. The applicant was reportedly working regular duty but did report heightened pain with driving.In an April 29, 2014 progress note, the applicant reported 2/10 elbow pain. The applicant had reportedly returned to his normal work duties as of that point in time. Well preserved elbow range of motion was noted without localized tenderness to touch. Sensorium was intact. The applicant apparently sustained a fracture of the radius while doing grip strength testing in the clinic. The applicant was placed off of work and asked to undergo an emergent open reduction and internal fixation surgery. The applicant had previously undergone a left-sided carpal tunnel release surgery on September 21, 2013 and underwent radial ORIF surgery on April 30, 2014.On September 30, 2014, the applicant reported persistent complaints of numbness about the hand and pain in the elbow, 3/10. The applicant noted that the previously requested nerve conduction testing of the left upper extremity and elbow MRI were both denied. Well preserved elbow range of motion was noted. The applicant was able to make a fist with the same. Numbness was noted about the left hand about the ulnar nerve distribution. It was stated that the applicant had residual numbness about

the hand following four previous arm surgeries. The applicant was given diagnosis of left radius fracture status post ORIF surgery, left upper extremity radiculopathy, left elbow chronic pain, and elbow epicondylitis. MRI imaging was endorsed to evaluate for possible ligamentous pathology. The applicant was placed off of work, on total temporary disability.Electrodiagnostic testing was apparently performed on October 16, 2014, and was interpreted as normal EMG and NCV testing of the left upper extremity. On September 2, 2014, the attending provider noted that the applicant was complaining of worsening pain about the elbow with associated hand paresthesias, tingling, and weakness. The attending provider suggested that electrodiagnostic testing was being performed to evaluate for possible cubital tunnel syndrome versus residual carpal tunnel syndrome following earlier carpal release surgery. MRI imaging of elbow was ordered to evaluate for epicondylitis versus possible ligamentous tear.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI of Left Elbow:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 33-34 and Tables l0-5 & l0-6.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 42.

**Decision rationale:** The attending provider indicated above that the elbow MRI in question was intended to distinguish the presence of a possible ligamentous tear versus underlying epicondylitis. The attending provider stated that he was at a loss to explain the applicant's current symptoms status post multiple elbow surgeries, including several prior ORIF surgeries. As noted in the MTUS-adopted ACOEM Guidelines in Chapter 10, Table 4, MRI imaging is "recommended" for suspected ulnar collateral ligament tears. The requesting provider is the same surgeon who previously operated upon the applicant on two prior occasions, making it likely that the applicant would act on the results of the study in question if positive. Therefore, the request is medically necessary.

**EMG Study:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 13.

**Decision rationale:** As noted in the MTUS-adopted ACOEM Guidelines in Chapter 10, Table 2, page 13, abnormalities on EMG are later findings typical of more advanced stages of ulnar nerve entrapment. In this case, the attending provider has posited that the applicant's upper extremity paresthesias are more likely than not a function of residual ulnar nerve entrapment, but has indicated that cervical radiculopathy and/or a residual carpal tunnel syndrome status post earlier

carpal tunnel release surgery are also possible considerations. The EMG testing at issue can, thus, help to differentiate between several of the suspected diagnoses here. Therefore, the request is medically necessary.