

Case Number:	CM14-0175909		
Date Assigned:	10/29/2014	Date of Injury:	05/05/2011
Decision Date:	02/11/2015	UR Denial Date:	10/17/2014
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 Physical Medicine Rehab, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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 56 year old male with a work injury dated 5/5/11. The diagnoses include right elbow pain status post right elbow biceps tendon repair and radial tunnel release June 2014. Under consideration are requests for EMG (electromyography) of 2 extremities, QTY: 1; Motor NCV (nerve conduction velocity) of upper extremities, QTY: 2; Sensory NCV (nerve conduction velocity) of the upper extremities. There is a progress note dated 9/8/14 that states that the patient is status post right elbow biceps tendon repair with radial tunnel release and continued symptoms of pain. The patient notes that he has made a moderate degree of improvement, since his prior evaluation; however, notes he does continue to have difficulty with occasional use of the arm. Apparently he has been unable to work modified duty, as nothing is available to him. He has been using a compound cream as necessary for pain control. He occasionally has shoulder pain. The patient denies any frank new history of injury and is otherwise without complaints. The patient notes that recently he has started develop numbness and tingling into his bilateral hands without any frank history of injury. On exam he is alert and oriented and in no acute distress. On examination of the bilateral upper extremities reveals he does have full active and symmetric range of motion noted. The patient's compartments are soft. Sensation is intact throughout to light touch with excellent capillary refill noted. On the right elbow, his wounds are otherwise healed. He does have a positive Tinel maneuver to bilateral elbow ulnar nerve with radiating symptoms extending down to his hand. There is no gross evidence of instability appreciated. He is neurovascularly intact. The impression is History of right elbow biceps tendon repair, radial tunnel release, elbow osteoarthritis and possible cubital tunnel syndrome versus radiculopathy. The plan states that due to his new onset of paresthesias into the upper extremity. The provider recommends a nerve conduction test to his bilateral upper extremities to rule out cubital tunnel syndrome versus radiculopathy.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG (electromyography) of 2 extremities, QTY: 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 13, 33. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, and Hand, Electrodiagnostic Studies (EDS)

Decision rationale: EMG (electromyography) of 2 extremities, QTY: 1 is not medically necessary, per the MTUS ACOEM and the Official Disability Guidelines (ODG). The MTUS ACOEM states that a Hoffman- Tinel's sign is thought to be not as helpful as it is often abnormal in the absence of symptoms. The clinical symptoms of ulnar neuropathy at the elbow are pain and paresthesias in the ring and fifth digits with sparing of the dorsal surfaces. With ulnar nerve entrapment at the elbow nerve conduction studies can be done above and below the elbow. Electromyography (EMG) study can be done if cervical radiculopathy is suspected as a cause of lateral arm pain, and that condition has been present for at least 6 weeks. Nerve conduction study and possibly EMG can be performed for ulnar nerve entrapment at the elbow 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. The ODG states that electrodiagnostic studies are recommended as an option after closed fractures of distal radius & ulna if necessary to assess nerve injury. They are also recommended for diagnosis and prognosis of traumatic nerve lesions or other nerve trauma. Electrodiagnostic testing includes testing for nerve conduction velocities (NCV), and possibly the addition of electromyography (EMG). In this case, the documentation states that the patient is neurovascular intact. The patient has a positive Tinel at the elbow which the MTUS state is often abnormal in the absence of symptoms. Additionally, the patient does not have symptoms in the left upper extremity; therefore, there is no need for electrodiagnostic testing in this limb. As such, the request for EMG (electromyography) of 2 extremities, QTY: 1 is not medically necessary.

Motor NCV (nerve conduction velocity) of upper extremities, QTY: 2: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 13, 33. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, and Hand, Electrodiagnostic Studies (EDS)

Decision rationale: Motor NCV (nerve conduction velocity) of upper extremities, QTY: 2 are not medically necessary per the MTUS Guidelines. The MTUS states 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 or four weeks. The MTUS ACOEM states that a Hoffman- Tinel's sign is thought to be not as helpful as it is often abnormal in the absence of symptoms. The clinical symptoms of ulnar neuropathy at the elbow are pain and paresthesias in the ring and fifth digits with sparing of the dorsal surfaces. With ulnar nerve entrapment at the elbow nerve conduction studies can be done above and below the elbow. The documentation states that the patient is neurovascular intact. The patient has a positive Tinel at the elbow which the MTUS state is often abnormal in the absence of symptoms. Additionally, the patient does not have symptoms in the left upper extremity; therefore, there is no need for electrodiagnostic testing in this limb. As such, this request for motor NCV (nerve conduction velocity) of upper extremities, QTY: 2 are not medically necessary.

Sensory NCV (nerve conduction velocity) of the upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 13, 33. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, and Hand, Electrodiagnostic Studies (EDS)

Decision rationale: Sensory NCV (nerve conduction velocity) of the upper extremities is not medically necessary per the MTUS Guidelines. The MTUS states 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 or four weeks. The MTUS ACOEM states that a Hoffman- Tinel's sign is thought to be not as helpful as it is often abnormal in the absence of symptoms. The clinical symptoms of ulnar neuropathy at the elbow are pain and paresthesias in the ring and fifth digits with sparing of the dorsal surfaces. With ulnar nerve entrapment at the elbow nerve conduction studies can be done above and below the elbow. The documentation states that the patient is neurovascular intact. The patient has a positive Tinel at the elbow which the MTUS state is often abnormal in the absence of symptoms. Additionally, the patient does not have symptoms in the left upper extremity; therefore, there is no need for electrodiagnostic testing in this limb. As such, the request for sensory NCV (nerve conduction velocity) of the upper extremities is not medically necessary.