

<b>Case Number:</b>	CM15-0002153		
<b>Date Assigned:</b>	01/13/2015	<b>Date of Injury:</b>	10/08/2014
<b>Decision Date:</b>	03/16/2015	<b>UR Denial Date:</b>	12/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/06/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California, New York, Florida  
 Certification(s)/Specialty: Internal Medicine, Pulmonary Disease, Critical Care Medicine

### 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 injured worker is a 29-year-old female who reported an injury on 10/08/2014 due to cumulative trauma. The clinical note dated 11/25/2014 noted that the injured worker had complaints of pain in the shoulders, hands, and right upper arm, forearm, and elbow. Upon examination of the right elbow there was tenderness noted over the lateral joint lines and lateral epicondyle. There was 4/5 strength with flexion and extension and 5/5 with pronation and supination. There was normal range of motion. Examination of the right hand revealed tenderness over the palmar aspect with a positive Phalen's. There was a positive Tinel's sign at the median nerve and manual muscle testing revealed 5/5 strength with dorsiflexion, palmar flexion, radial deviation, and ulnar deviation. The diagnosis were right forearm derangement, right lateral epicondylitis, and right wrist/hand derangement. The provider recommended an EMG/NCV of the bilateral upper extremities to rule out carpal tunnel syndrome and the use of the elbow brace. The Request for Authorization form was not included in the medical documents for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**EMG/NCV of the Bilateral Upper Extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation ODG, Electrodiagnostic Studies (EDS)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation, Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

**Decision rationale:** The request for an EMG/NCV of the bilateral upper extremities is not medically necessary. The California MTUS/ACOEM Guidelines state that electromyography and nerve conduction velocity, including H reflex tests, may be helpful to identify subtle focal neurologic dysfunction in injured workers with neck or arm symptoms (or both) lasting more than 3 to 4 weeks. The Official Disability Guidelines do not recommend nerve conduction studies and state that there is minimal justification for performing nerve conduction studies when an injured worker is presumed to have symptoms on the basis of radiculopathy. There is limited evidence to support the use of often uncomfortable and costly EMG/NCVs. There was a lack of documentation of the injured worker's failure to respond to initially recommended conservative treatment. The documentation submitted for review noted right sided deficits to the wrist and hand. No rationale for a bilateral neurodiagnostic studies. There were only deficits noted on 1 side. Additionally, an NCV is not recommended for the upper extremities. There was no evidence of a failed trial of conservative treatment. As such, medical necessity has not been established.

**Tennis Elbow Brace:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007). Decision based on Non-MTUS Citation ODG, Splinting/Padding for Elbow Injuries

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 6, page(s) 596.

**Decision rationale:** The request for a tennis elbow brace is not medically necessary. The California MTUS/ACOEM Guidelines state that bracing for lateral epicondylitis is under study. In general, immobilization should be avoided. The exception is immediately after surgery where brief immobilization may be required. There was insufficient evidence to support an elbow brace by the referenced guidelines. As such, medical necessity has not been established.