

<b>Case Number:</b>	CM15-0135593		
<b>Date Assigned:</b>	07/23/2015	<b>Date of Injury:</b>	10/11/2013
<b>Decision Date:</b>	08/20/2015	<b>UR Denial Date:</b>	06/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/14/2015

### 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, Indiana, New York  
 Certification(s)/Specialty: Internal 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 (IW) is a 56 year old male who sustained an industrial injury on 10/11/2013. He reported a continual trauma resulting in pain, numbness and tingling of both hands radiating into the elbows, left more than right and pain in both shoulders. The injured worker was diagnosed as having bilateral upper extremity lateral epicondylitis and bilateral cubital tunnel syndrome, carpal tunnel syndrome, right upper extremity flexor/extensor tenosynovitis, and right shoulder myofascial strain. Treatment to date has included two view x-rays of both the right and left elbows and of the wrists. All of the x-rays were unremarkable with exception of the right wrist which had a 2mm positive ulnar variance without fracture or dislocation. Treatments include medication, physical therapy, home exercise, and H-Wave. In the exam of 06/ 15/2015, the injured worker complains of left elbow numbness to the 4th and 5th finger severely increased. His pain level on examination was a 7-8 on a scale of 0-10. On exam he is tender to palpation over the cubital area. Range of motion of the left elbow is painful. Medication helps decrease his symptoms, as does a brace, supervised physical therapy and a home exercise program. The plan of treatment was for Pil-O-Splints, and electromyogram/nerve conduction velocity of the left upper extremity. Voltaren XR was started. A request for authorization was made for an EMG/NCV Left Upper Extremity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **EMG/NCV Left Upper Extremity: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck section, EMG/NCV.

**Decision rationale:** Pursuant to the Official Disability Guidelines, EMG/NCV of the left upper extremity is not medically necessary. The ACOEM states (chapter 8 page 178) unequivocal findings that identifies specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Nerve conduction studies are not recommended to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but recommended if the EMG is not clearly radiculopathy or clearly negative or to differentiate radiculopathy from other neuropathies or non-neuropathies if other diagnoses may be likely based on physical examination. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms because of radiculopathy. While cervical electrodiagnostic studies are not necessary to demonstrate his cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality, diabetic property or some problem other than cervical radiculopathy. In this case, the injured worker's working diagnoses are bilateral upper extremity overuse flexor/extensor tenosynovitis of the forearm, wrist, hands; bilateral elbow medial and lateral epicondylitis; bilateral cubital tunnel syndrome rule out carpal syndrome. The date of injury is October 11, 2013. Request authorization is dated June 17, 2015. According to an agreed-upon medical examination (AME) dated February 19, 2014, the injured worker had a prior EMG/NCV of the upper extremity(s). The documentation is not clear as to whether the study included the right upper extremity, left upper extremity or bilateral upper extremities. There was no hard copy of the EMG/NCV report. According to a June 15, 2015 progress note, the injured worker has bilateral elbow numbness and tingling. The documentation is otherwise largely illegible. The EMG/MCV dated February 19, 2014 had a normal nerve conduction velocity study and the EMG showed findings compatible with cubital tunnel syndrome. There is no documentation demonstrating a progression of symptoms and/or clinical findings based on the documentation. There are no new symptoms or objective physical findings indicating a repeat of electrodiagnostic study is indicated. Consequently, absent clinical documentation with a progression of clinical symptoms and objective findings and EMG/NCV dated February 19, 2014 with a normal nerve conduction study and an EMG that showed cubital tunnel syndrome, EMG/NCV of the left upper extremity is not medically necessary.