

<b>Case Number:</b>	CM15-0188141		
<b>Date Assigned:</b>	09/30/2015	<b>Date of Injury:</b>	06/15/2014
<b>Decision Date:</b>	11/10/2015	<b>UR Denial Date:</b>	09/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/24/2015

### 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, District of Columbia, Maryland  
 Certification(s)/Specialty: Anesthesiology, Pain Management

### 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 64-year-old female, who sustained an industrial injury on 6-15-14. The documentation on 9-14-15 noted that the injured worker has complaints of right hand pain that begins at her wrist and radiates upwards to her elbow and feels like pins and needles and complaints of neck and shoulder pain. The documentation noted that the injured worker had been placed on regular duty, but did not return to work because she stated she became very nervous, anxious and her doctor took her off of work. The right elbow had tenderness to palpation; medial epicondyle was positive; Tinel's sign was positive and there was subluxation of the ulnar nerve about the elbow with flexion and extension. Right wrist has tenderness to palpation; Tinel's sign is positive and Tinel's test of the right wrist is positive. The documentation noted that the injured worker has not worked since 8-14. The diagnoses have included medial epicondylitis; pain in limb an ulnar nerve lesion. Treatment to date has included approximately 8 sessions of therapy and acupuncture. Current medications listed on 9-14-15 were noted as aspirin; lorazepam; meloxicam; methocarbamol; mirtazapine; naproxen; olanzapine; simvastatin and temazepam. The original utilization review (9-21-15) non-certified the request for right upper extremity electromyography and nerve conduction study.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right upper extremity EMG:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, and Elbow Complaints 2007, and Forearm, Wrist, and Hand Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back, Electromyography (EMG) Official Disability Guidelines, Neck and Upper Back, Nerve Conduction Studies (NCS).

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

**Decision rationale:** ACOEM guidelines support ordering of imaging studies for emergence of red flags, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies 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. 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. Per MTUS ACOEM p182, with regard to the detection of neurologic abnormalities, EMG for diagnosis of nerve root involvement if findings of history, physical exam, and imaging study are consistent, is not recommended. Per the medical records submitted for review, EMG/NCV was completed 8/14/14. Study of the ulnar and median nerves as well as needle study of the right upper extremity to rule out cervical radiculopathy was performed. The documentation submitted for review does not contain interval evidence of new neurologic dysfunction such as sensory, reflex, or motor system deficit. The request is not medically necessary.

**Right upper extremity NCS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, and Elbow Complaints 2007, and Forearm, Wrist, and Hand Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back, Electromyography (EMG) Official Disability Guidelines, Neck and Upper Back, Nerve Conduction Studies (NCS).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Nerve conduction studies (NCS).

**Decision rationale:** Per the ODG guidelines with regard to NCS: Not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. (Utah, 2006) This systematic review and meta-analysis demonstrate that neurological testing procedures have limited overall diagnostic accuracy in detecting disc herniation with suspected radiculopathy. (Al Nezari, 2013) In the management of spine trauma with radicular symptoms, EMG/nerve conduction studies (NCS) often have low combined sensitivity and specificity in confirming root injury, and there is limited evidence to support the use of often uncomfortable and costly EMG/NCS. (Charles, 2013) See also the Carpal Tunnel Syndrome Chapter for more details on NCS. Studies have not shown portable nerve conduction devices to be effective. EMGs (electromyography) are recommended as an option (needle, not surface) to obtain unequivocal evidence of

radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. As the requested treatment is not recommended, and there is no compelling reason given to support medical necessity, the request is not medically necessary.