

Case Number:	CM15-0224064		
Date Assigned:	11/20/2015	Date of Injury:	10/10/2013
Decision Date:	12/30/2015	UR Denial Date:	11/11/2015
Priority:	Standard	Application Received:	11/14/2015

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

Certification(s)/Specialty: Preventive Medicine, Occupational 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 54-year-old female, with a reported date of injury of 10-10-2013. The diagnoses include lateral epicondylitis, elbow pain, and medial epicondylitis. The progress report dated 10-19-2015 indicates that the injured worker stated that she continued to have some problems with her elbows and was doing well until the prior week when she had to get on her hands and knees to check something. This caused her left elbow to flare-up. She stated that she had some increased pain at both the medial and lateral aspect of the elbow extending to the forearm and some extending up into the upper arm. It was noted that the injured worker continued to have some numbness in her left small finger and ring finger. The objective findings include no swelling or atrophy of the left elbow; some tenderness over the medial and lateral epicondyle areas of the elbow; good range of motion to flexion and extension with some discomfort with supination; mildly positive Tinel's of the elbow; some decreased sensation in the ulnar distribution of the left hand in the small finger mainly and slightly in the ring finger; full range of motion of all the digit; good hand grip strength; and some discomfort with forceful gripping with her left hand up to the forearm and elbow. The treating physician indicates that the injured worker has had several electrodiagnostic studies, which were initially normal, but the latest showed some borderline evidence of cubital tunnel. The injured worker has been instructed to return to full duty. The treating physician felt that the injured worker had reached permanent and stationary status. The medical records did not include the prior electrodiagnostic study reports. The diagnostic studies to date have not been included in the medical records provided. Treatments and evaluation to date have included Relafen. The request for authorization was

dated 10-19-2015. The treating physician requested an EMG (electromyography) of the left upper extremity and NCS (nerve conduction study) of the left upper extremity. On 11-11-2015, Utilization Review (UR) non-certified the request for an EMG (electromyography) of the left upper extremity and NCS (nerve conduction study) of the left upper extremity.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG left upper extremity Qty 1: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies.

Decision rationale: The MTUS Guidelines state that unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to order imaging studies if symptoms persist. When neurologic examination is less clear, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. EMG and NCV may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. In this case, the treating physician indicates that the injured worker has had several electrodiagnostic studies, which were initially normal, but the latest showed some borderline evidence of cubital tunnel. The prior studies have not been made available for review. While there is evidence of nerve compromise on physical examination, there have also reportedly been many electrodiagnostic studies completed in the past. There is no indication, at this time, for another EMG. The request for EMG left upper extremity Qty 1 is not medically necessary.

NCS left upper extremity Qty 1: Upheld

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Diagnostic Criteria.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back Chapter/Nerve Conduction Studies (NCS) Section.

Decision rationale: The MTUS Guidelines address the use of NCS in detection of neurological abnormalities at the elbow and wrist. The ODG does not recommend the use of NCS 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-neuropathic process if other diagnoses may be likely based on the clinical exam. There is minimal justification for performing NCS when a patient is already presumed to have symptoms on the basis of

radiculopathy. While cervical electrodiagnostic studies are not necessary to demonstrate a cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality, diabetic neuropathy, or some problem other than a cervical radiculopathy, with caution that these studies can result in unnecessary over treatment. In this case, the treating physician indicates that the injured worker has had several electrodiagnostic studies, which were initially normal, but the latest showed some borderline evidence of cubital tunnel. The prior studies have not been made available for review. While there is evidence of nerve compromise on physical examination, there have also reportedly been many electrodiagnostic studies completed in the past. There is no indication, at this time, for another EMG. The request for NCS left upper extremity Qty 1 is not medically necessary.