

<b>Case Number:</b>	CM15-0031123		
<b>Date Assigned:</b>	02/24/2015	<b>Date of Injury:</b>	10/27/2004
<b>Decision Date:</b>	04/07/2015	<b>UR Denial Date:</b>	02/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/19/2015

### 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: New Jersey, Michigan, California  
 Certification(s)/Specialty: Neurology, Neuromuscular 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 was a 62 year old female, who sustained an industrial injury, October 27, 2004, October 5, 2006 through October 5, 2007, December 29, 1989 through October 4, 2008. According to progress note of February 20, 2015, the injured workers chief complaint was neck pain and right upper extremity numbness. On February 20, 2015 the EMG/NCS (electromyography and nerve conduction studies) were unchanged from the prior study completed on May 17, 2014. The injured worker was diagnosed with C5-C8 radiculopathy and mild elbow ulnar motor neuropathy. The injured worker previously received the following treatments EMG/NCS (electromyography and nerve conduction studies) of May 17, 2014 and repeat studies on February 20, 2015. On January 26, 2015, the primary treating physician requested denied authorization for EMG/NCS (electromyography and nerve conduction studies) for right ulnar nerve lesion/cubital tunnel syndrome. The injured worker had left shoulder surgery 2005, right wrist arthroscopic surgery 2007. Cervical spine surgery 2011, right elbow ulnar nerve release 2013 and right carpal tunnel release 2013. On February 2, 2015, the Utilization Review denied authorization for EMG/NCS (electromyography and nerve conduction studies) for right ulnar nerve lesion/cubital tunnel syndrome. The denial was based on the MTUS/ACOEM and ODG guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**EMG/NCS Right ulnar nerve lesion/cubital tunnel syndrome:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC); Elbow Procedure Summary.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 269.

**Decision rationale:** According to MTUS guidelines (MTUS page 303 from ACOEM guidelines), Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. EMG has excellent ability to identify abnormalities related to disc protrusion (MTUS page 304 from ACOEM guidelines). According to MTUS guidelines, needle EMG study helps identify subtle neurological focal dysfunction in patients with neck and arm symptoms. 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 (page 178). EMG is indicated to clarify nerve dysfunction in case of suspected disc herniation (page 182). EMG is useful to identify physiological insult and anatomical defect in case of neck pain (page 179). There is no documentation of peripheral nerve damage, cervical radiculopathy and entrapment neuropathy that requires electro diagnostic testing. There is no documentation of significant change in the patient condition. Therefore, the request for EMG/NCS is not medically necessary.