

<b>Case Number:</b>	CM15-0037919		
<b>Date Assigned:</b>	03/06/2015	<b>Date of Injury:</b>	04/01/2012
<b>Decision Date:</b>	04/16/2015	<b>UR Denial Date:</b>	02/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/27/2015

### 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: Physical Medicine & Rehabilitation

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 38 year old female sustained an industrial injury on 4/1/12, with subsequent ongoing bilateral upper extremity pain. Electromyography/nerve conduction velocity test bilateral upper extremity (4/24/14), showed mild right carpal tunnel syndrome and mild bilateral cubital tunnel syndrome. The injured worker underwent right carpal tunnel release on 10/3/14. In a supplemental report dated 1/29/15, the injured worker complained of residual paresthesias along the median nerve distribution and persistent intermittent paresthesias along the ulnar distribution when she did not use the elbow sleeve. Physical exam was remarkable for slight pillar tenderness to palpation with unremarkable range of motion, slight subluxation of the ulnar nerve with maneuvers of flexion and extension, positive right compression, Tinel's and provocative tests. The physician's impression was slightly improved right cubital tunnel syndrome with residual paresthesias four months after endoscopic assisted right carpal tunnel release. Treatment plan included continuing right hand strengthening, sensory reeducation and desensitization exercises, considering scar massage, silicone patch in the area of the scar and continuing elbow sleeve. The physician noted that if the injured worker remained symptomatic regarding the median nerve 8-10 months after surgery, she would require repeat electromyography/nerve conduction velocity test and magnetic resonance imaging for further assessment.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**NCS (Nerve conduction studies)/ EMG (electromyogram) - Neck extending to right upper extremity:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 238, table 10-6. Decision based on Non-MTUS Citation Official Disability Guidelines: Neck & Upper Back chapter.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 8 Neck and Upper Back Complaints Page(s): 177-178, 260-262.

**Decision rationale:** The 2/04/15 Utilization Review letter states the NCS (nerve conduction studies) EMG (electromyogram) neck extending to the right upper extremity requested on the 1/15/15 medical report was denied because "Evidence based guidelines necessitate documentation of subjective/objective findings consistent with radiculopathy/nerve entrapment that has not responded to conservative treatment to support the necessity of EMG/NCV." According to the 1/15/15 occupational medicine report, the patient is in for evaluation of carpal tunnel syndrome, status post carpal tunnel release and bilateral epicondylitis. The symptoms are reported to be worsening. She now has some decreased sensation in a dermatomal pattern in the right forearm. The symptoms are increasing despite continued use of the brace, and medications. The physician requests an EMG/NCV of the right arm for evaluation to see if the new dermatomal symptoms could be coming from the brachial plexus or cervical roots. MTUS/ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8, Neck and Upper Back Complaints, Special Studies and Diagnostic and Treatment Considerations, page 178 states: "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." MTUS/ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11, Forearm, Wrist, and Hand Complaints, page 260-262 states: "Appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful. NCS and EMG may confirm the diagnosis of CTS but may be normal in early or mild cases of CTS. If the EDS are negative, tests may be repeated later in the course of treatment if symptoms persist." The request for EMG/NCV of the right upper extremity/neck is in direct accordance with MTUS/ACOEM guidelines for evaluation of the new dermatomal distribution of symptoms superposed on prior median nerve findings from carpal tunnel syndrome. The request for NCS (nerve conduction studies