Case Number:	CM14-0126662		
Date Assigned:	08/13/2014	**Date of Injury:**	06/15/2013
Decision Date:	10/23/2014	**UR Denial Date:**	07/29/2014
Priority:	Standard	**Application Received:**	08/11/2014

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. The expert reviewer is Board Certified in Internal Medicine and Pulmonary Diseases and is licensed to practice in Florida, New York and California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 53-year-old female who reported a work related injury on 06/15/2013. The mechanism of injury was not provided for review. The injured worker's diagnoses consist of lateral epicondylitis of the left elbow and cubital tunnel syndrome. The injured worker's past treatment has included physical therapy. The injured worker's diagnostics consisted of an x-ray of the left wrist which demonstrated normal bony mineralization for age with no evidence of fracture or dislocation. Past surgical history has included a left cubital tunnel release with anterior subcutaneous transposition of the ulnar nerve on 02/21/2014. Upon examination on 07/16/2014, the injured worker complained of paresthesias and numbness along the ulnar border of the small finger and hand down to the level of the wrist flexion creases which has been fairly consistent since before her surgery and even following her surgery. The injured worker stated after surgery her sensation has improved on the right finger and the radial border of her small finger. Upon physical examination, it was noted that the injured worker's sensation was intact to light touch both anterior and posterior to the incision at the elbow. Distally at the forearm, she has normal sensation in a radial, median, and ulnar nerve distribution down to the level of the wrist flexion creases. Along the ulnar border of the hand and small finger, however, she reported decreased sensation. Dorsally on the small finger and hand she had intact sensation in the dorsal ulnar sensation branch distribution. The injured worker also stated she had difficulty with 2 point discrimination on the ulnar border of the small finger, while 2 point discrimination was normal on the radial border. Tinel's testing at the Guyon's canal and cubital tunnel and in the region of the anterior ulnar nerve transposition was unremarkable. The injured worker's medications were not provided for review. The treatment plan consisted to obtain a new nerve conduction study. The rationale for the request was to distinguish an area of compression around the Guyon's canal. A request for authorization form was submitted for review on 07/22/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electromyography Left upper Extremity: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-269.

Decision rationale: The request for an electromyography of the left upper extremity is not medically necessary. The California MTUS/ACOEM Guidelines state appropriate electrodiagnostic studies may help to differentiate between carpal tunnel syndrome and other conditions, such as cervical radiculopathy. These may include nerve conduction studies, or in more difficult cases, electromyography may be helpful. Nerve conduction studies and electromyography may confirm the diagnosis of carpal tunnel syndrome but may be normal in early or mild cases of CTS. The medical records submitted for review state the injured worker underwent a left carpal tunnel syndrome release. However, she continued to report parathesias and numbness along the ulnar border of the small finger and hand down to the level of the wrist flexion creases which has been consistent since before and after her surgery. The injured worker was also noted to have unremarkable Tinel's and Guyon's canal testing. The guidelines also state special studies are not needed until 4 to 6 weeks of conservative care and observation have been completed. Additionally, the Official Disability Guidelines state, seldom is it required that both an NCV and an EMG be accomplished in straightforward condition of median and ulnar neuropathies or peroneal nerve compression neuropathies. The addition of an EMG will not supply any further clinical information. Therefore, the request for an electromyography of the upper left extremity is not medically necessary.