MAXIMUS Federal Services

Case Number:	CM14-0212703		
Date Assigned:	12/30/2014	Date of Injury:	02/27/2012
Decision Date:	02/27/2015	UR Denial Date:	12/02/2014
Priority:	Standard	Application Received:	12/19/2014

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. 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, Indiana, New York
Certification(s)/Specialty: Internal 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 (IW) is a year-old-man with a date of injury of February 27, 2013. The mechanism of injury is not documented in the medical record. The injured worker 's working diagnosis is chronic residual ulnar neuritis left elbow, possible ulnar entrapment Guyon's canal of the left wrist with mild chronic complex regional pain syndrome with hypersensitivity left elbow. The IW underwent surgical intervention for chronic and progressive ulnar nerve entrapment on August 17, 2012. Pursuant to the comprehensive orthopedic evaluation dated October 16, 2014, the IW was placed on permanent and stationary disability on March 28, 2013 with the ulnar nerve residuals from severely injured ulnar nerve with chronic ulnar nerve changes found at the timer of surgery. He complains of residual hypersensitivity, some occasional numbness and loss of motor strength. He presents simply questioning whether or not there is anything else that can be done for his residual symptoms. On physical examination, the IW has hypersensitivity to soft tissue touch along the medial aspect of the elbow around the skin no isolated just to the transposed ulnar nerve. He also has tenderness over the ulnar nerve and the Guyon's canal. Range of motion is complete 0-135 degrees with no evidence of subluxation pattern of the transposed nerve. The treating physician is recommending the IW be seen by a neurologist and have repeat EMG studies. The current request is for EMG/NCV 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 of the left upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007). Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Elbow Section, EMG/NCV.

Decision rationale: Pursuant to the ACOEM and the Official Disability Guidelines, EMG of the left upper extremity is not medically necessary. The ACOEM supports EMG studies to identify subtle, focal neurologic dysfunction in patients with upper back symptoms lasting more than three or four weeks. The Official Disability Guidelines support EMG after one month conservative treatment. EMGs and NCVs are not necessary if radiculopathy is already clinically obvious. Nerve conduction studies are not recommended in the guidelines. There is minimal justification for performing nerve conduction studies when the patient is presumed to have symptoms on the basis of radiculopathy. EMGs are recommended as an option to obtain unequivocal evidence of radiculopathy, after one month conservative therapy, but EMGs are not necessary if radiculopathy already clinically obvious. In this case, the injured worker's working diagnosis is chronic residual ulnar neuritis left elbow, possible ulnar entrapment Guyon's canal of the left wrist with mild chronic complex regional pain syndrome with hypersensitivity. The documentation in an October 16, 2014 progress note indicates the injured worker was placed on permanent and stationary disability on March 28, 2013. The injured worker had ulnar residuals from severely injured ulnar nerve with chronic ulnar nerve changes found at the time of the nerve transposition. The injured worker presented (October 16, 2014) because he still remains with residual complaints of hypersensitivity, some occasional numbness and also some loss of motor strength. The worker is here simply questioning whether or not there is anything else that can be done for his residual symptoms. There has been no new intervening injury. The diagnosis reflects a chronic ongoing condition. The treatment plan includes a consultation with a neurologist as well as EMG/NCV to determine whether or not there could also be residual entrapment at Guyon's canal. There is no clinical information regarding the presurgical status of the affected wrist and the clinical findings at that time. There are no objective findings of neurologic dysfunction such as sensory or motor defects and how these findings have changed from the postoperative period of the present. Consequently, absent clinical documentation to support a clinical change in the objective findings and chronic ongoing complaints since the surgery, EMG of the left upper extremity is not medically necessary.

NCV of the left upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007). Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Elbow Section, EMG/NCV.

Decision rationale: Pursuant to the ACOEM and the Official Disability Guidelines, NCV of the left upper extremity is not medically necessary. The ACOEM supports EMG studies to identify subtle, focal neurologic dysfunction in patients with upper back symptoms lasting more than three or four weeks. The Official Disability Guidelines support EMG after one month conservative treatment. EMGs and NCVs are not necessary if radiculopathy is already clinically obvious. Nerve conduction studies are not recommended in the guidelines. There is minimal justification for performing nerve conduction studies when the patient is presumed to have symptoms on the basis of radiculopathy. EMGs are recommended as an option to obtain unequivocal evidence of radiculopathy, after one month conservative therapy, but EMGs are not necessary if radiculopathy already clinically obvious. In this case, the injured worker's working diagnosis is chronic residual ulnar neuritis left elbow, possible ulnar entrapment Guyon's canal of the left wrist with mild chronic complex regional pain syndrome with hypersensitivity. The documentation in an October 16, 2014 progress note indicates the injured worker was placed on permanent and stationary disability on March 28, 2013. The injured worker had ulnar residuals from severely injured ulnar nerve with chronic ulnar nerve changes found at the time of the nerve transposition. The injured worker presented (October 16, 2014) because he still remains with residual complaints of hypersensitivity, some occasional numbness and also some loss of motor strength. The worker is here simply questioning whether or not there is anything else that can be done for his residual symptoms. There has been no new intervening injury. The diagnosis reflects a chronic ongoing condition. The treatment plan includes a consultation with a neurologist as well as EMG/NCV to determine whether or not there could also be residual entrapment at Guyon's canal. There is no clinical information regarding the presurgical status of the affected wrist and the clinical findings at that time. There are no objective findings of neurologic dysfunction such as sensory or motor defects and how these findings have changed from the postoperative period of the present. Consequently, absent clinical documentation to support a clinical change in the objective findings and chronic ongoing complaints since the surgery, NCV of the left upper extremity is not medically necessary.