

<b>Case Number:</b>	CM15-0075461		
<b>Date Assigned:</b>	06/11/2015	<b>Date of Injury:</b>	09/03/2014
<b>Decision Date:</b>	07/16/2015	<b>UR Denial Date:</b>	04/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/21/2015

### 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:

The injured worker is a 49 year old male, who sustained an industrial injury on September 3, 2014. He reported an injury to his left elbow. Treatment to date has included MRI of the left elbow, left elbow lateral epicondylar release, physical therapy and medication. Currently, the injured worker complains of worsening of his left shoulder symptoms and paresthasias involving the ulnar three digits of his left upper extremity. He reports that his shoulder was not symptomatic prior to his surgical intervention on the left elbow. He reports intermittent numbness and tingling in the ulnar three digits and notes that he has pain in the morning when he awakens. He reports weakness of the left hand and left shoulder strength. On physical examination the injured has tenderness to palpation of the subacromial region and the biceps tendon. There was subacromial crepitus noted. Neer's and Hawkins's impingement signs are positive and there is subacromial pain with passive range of motion. An MRI of the left elbow on October 23, 2014 revealed moderate lateral epicondylitis with a partial thickness tear at the attachment site to the lateral epicondyle. The diagnoses associated with the request include status post left elbow lateral epicondylar release, left rotator cuff tendonitis with impingement of the left shoulder and left ulnar nerve neuropathy of cubital tunnel. The treatment plan includes MRI of the left shoulder, cortisone injection, EMG/NCV of the left upper extremity, left elbow physical therapy and follow-up evaluation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**EMG/NCV for left upper extremity:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 207-208, 261.

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

**Decision rationale:** Based on the 4/2/15 progress report provided by the treating physician, this patient presents with improved left elbow pain but progressively worse left shoulder pain with paresthesias involving ulnar 3 digits of his left upper extremity. The treater has asked for EMG/NCV FOR LEFT UPPER EXTREMITY on 4/2/15 to confirm the presence of a left ulnar nerve neuropathy at the cubital tunnel and left carpal tunnel syndrome. The patient's diagnoses per request for authorization form dated 4/8/15 is left rotator cuff tendonitis with impingement left shoulder. The patient is s/p unspecified left elbow surgery from 1/19/15 and continues to improve with left elbow per 4/2/15 report. The patient continues to attend occupational therapy which and is progressing with his left elbow per 4/2/15 report. The patient's left shoulder was not symptomatic prior to left elbow surgery but became symptomatic right after the surgery, although he had no new trauma or injury per 4/2/15 report. The patient also has ulnar nerve paresthesias which he states is very similar to what he had on his contralateral side, that was treated surgically per 4/2/15 report. The patient has intermittent numbness/tingling in his ulnar 3 digits, pain when he wakes up, and weakness of his left hand and left shoulder strength per 4/2/15 report. His pain level is currently 5/10 on VAS scale, and at its worst is 8/10 per 2/25/15 report. His surgical history is a prior right ulnar nerve release in 2009, lateral epicondyle release in 2009, a rotator cuff surgery and surgery to his biceps tendon in 2008, unspecified side per 2/25/15 report. The patient is currently not working and is temporarily totally disabled. ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11, 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." Treater requests EMG/NCV for left upper extremity "to confirm the presence of a left ulnar nerve neuropathy at the cubital tunnel and left carpal tunnel syndrome" per requesting progress report dated 4/2/15. In this case, there is no evidence that the patient has had prior left upper extremity EMG study done per review of reports dated 10/7/14 to 4/2/15. The patient continues with left shoulder pain, and paresthesias involving ulnar 3 digits of left upper extremity. Given the patient's upper extremity neuropathic symptoms with onset post 1/19/15 shoulder surgery, physical examination findings and diagnosis of left ulnar nerve neuropathy of cubital tunnel, EMG study would appear reasonable. Therefore, the request IS medically necessary.