

<b>Case Number:</b>	CM15-0091336		
<b>Date Assigned:</b>	05/15/2015	<b>Date of Injury:</b>	05/29/2012
<b>Decision Date:</b>	06/17/2015	<b>UR Denial Date:</b>	04/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/12/2015

### 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, 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 is a 41 year old male who sustained an industrial injury on 5/29/12 involving injury to his left arm. He has had ulnar nerve transposition, radial tunnel and lateral epicondylitis surgeries with reported poor results. The injured worker currently complains of numbness in the medial left hand, 4th and 5th digits; left elbow and posterior forearm pain that is exacerbated with gripping activity. He has no complaints of lower extremity pain. Diagnoses include left elbow pain, status post cubital tunnel release with residual; subjective numbness and normal EMG; left radial neuropathy; right carpal tunnel syndrome. Treatments to date include left elbow steroid injection with no relief. Diagnostics included left and right upper extremity electromyography and nerve conduction study left hand (4/23/15) which was abnormal; pre-surgical MRI showed lateral epicondylitis. In the progress note dated 4/13/15 the treating provider's plan of care included electromyography to access radial nerve. On 4/28/15 Utilization Review accessed the request for electromyography/ nerve conduction study of the upper and lower extremity, neck and face.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**EMG/NCV of the Upper and Lower Extremities, Neck and Face: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Comp, 13th edition, 2015, Forearm, Wrist, and Hand Chapter, Electrodiagnostic Studies (EDS).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck section, low back section, EMG/NCV.

**Decision rationale:** Pursuant to the Official Disability Guidelines, EMG/NCV upper and lower extremities, neck and face studies are not medically necessary. Nerve conduction studies are not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. EMGs may be useful to obtain unequivocal evidence of radiculopathy, after one-month conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious. The ACOEM states (chapter 8 page 178) unequivocal findings that identifies specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Nerve conduction studies are not recommended to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but recommended if the EMG is not clearly radiculopathy or clearly negative or to differentiate radiculopathy from other neuropathies or non-neuropathies if other diagnoses may be likely based on physical examination. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy. While cervical electrodiagnostic studies are not necessary to demonstrate his cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality, diabetic property or some problem other than cervical radiculopathy. In this case, the injured worker's working diagnoses elbow pain and radial neuropathy (lesion of radial nerve). The utilization review states the injured worker had electrodiagnostic studies on August 25, 2014 (not present in the medical record) and were normal. The injured worker has not had a worsening of the neurologic symptoms. Subjectively, according to an April 23, 2015 progress note, the review of systems states the injured worker has joint pain and stiffness in the joints. Pertinent negatives include no back pain and no neck pain. Neurologically, the injured worker complains of severe facial pain, tingling or pins and needles sensation and weakness. There is no facial drooping, headache. Objectively, examination of the head and face shows normal symmetry and no masses. HEENT is unremarkable. The left elbow showed a positive resistive tennis elbow test. Tinel's was negative. Motor examination was grossly intact in the shoulder, proximal upper extremities bilaterally, and distal upper extremities and hands bilaterally. Sensory examination for light touch showed hypoesthesia in the distribution of the ulnar nerve. Gait was normal. Consequently, absent clinical documentation with an indication in the medical record with subjective complaints and objective clinical findings to repeat an EMG/NCV of the upper extremities, lower extremities neck and face, EMG/NCV upper and lower extremities, neck and face studies are not medically necessary.