

Case Number:	CM13-0001098		
Date Assigned:	03/03/2014	Date of Injury:	04/19/2012
Decision Date:	05/08/2014	UR Denial Date:	07/02/2013
Priority:	Standard	Application Received:	07/12/2013

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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine and is licensed to practice in 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:

This is a 46 year-old male who was injured on 4/19/12. The 6/17/13 supplemental report from [REDACTED] is a record review of the 9/5/12 orthopedic report from [REDACTED], who lists the diagnoses as lumbar and cervical radiculopathy, and requests C5-6 artificial disc replacement. There was a 6/13/13 Request for Authorization (RFA) form from [REDACTED] for general surgery consult, psych consult, neurology consult, EMG/NCV for the upper and lower extremities, and an OrthoStim 4 unit. The medical report that discusses these items was not included for this IMR. On 7/2/13, UR recommended non-certification for the EMG/NCV upper and lower extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG TO THE UPPER EXTREMITIES: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines INTERFERENTIAL CURRENT STIMULATION Page(s): 117-119, 121. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, INTERFERENTIAL CURRENT STIMULATION, 117-119, 121

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

Decision rationale: The most recent medical examination available for this IMR is dated 4/25/13 from [REDACTED], he requested post-op cervical x-rays, compounded topicals for pain, PT for the cervical and lumbar spines, an EMG for BUE and BLE, a routine lumbar MRI, an IF unit. The report did not mention any cervical surgery being performed, and did not have reported exam findings suggestive of recent post-surgical changes. The most recent report available for this IMR, is the 11/1/13 supplemental report from [REDACTED]. This report states the patient underwent C5/6 disc replacement on 3/9/13, and has thoraco lumbar sprain with bilateral radiculitis, right foot plantar fasciitis, and a left inguinal hernia, and history of closed head trauma with headaches, stress, anxiety, depression and difficulty sleeping. [REDACTED] states the patient was seen at his office on 6/13/13, and there was numbness down the left arm, and both feet. The 6/13/13 evaluation was not provided for this IMR, but the 6/13/13 supplemental report/record review was available. [REDACTED] notes the patient still had decreased sensation in the C6-7 distribution. And there was numbness and tingling in both feet. The request before me is for EMG for both the left and non-symptomatic right upper extremities, 3-months post- C5/6 disc replacement surgery. The EMG for the left upper extremity appears appropriate, but I am not able to offer partial certification, and the request is for both upper extremities. There was no rationale provided for the electrodiagnostic studies on the right upper extremity. The request as written, for both left and right upper extremities is not in accordance with MTUS/ACOEM guidelines

EMG TO THE LOWER EXTREMITIES: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines INTERFERENTIAL CURRENT STIMULATION Page(s): 117-119, 121.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

Decision rationale: The patient is reported to have back pain, right plantar fasciitis, and numbness in both feet, with no positive neurologic examination findings. MTUS/ACOEM states "Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks." There was no prior back surgery reported, and no prior documentation of specific nerve root involvement. The request for EMG appears to be in accordance with MTUS/ACOEM guidelines for the bilateral lower extremities.

NCV TO THE UPPER EXTREMITIES: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines INTERFERENTIAL CURRENT STIMULATION Page(s): 117-119, 121.

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

Decision rationale: The patient presents with history of C5/6 disc replacement and left-sided radiculopathy. The request before me is for NCV for both upper extremities. There are no clinical exam findings of peripheral neuropathy/carpal tunnel syndrome, or radiculopathy on the right arm. ODG guidelines state NCS is "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-neuropathic processes if other diagnoses may be likely based on the clinical exam" There are no subjective or objective findings to suggest right-sided radiculopathy or peripheral neuropathy in the right upper extremity. The request does not appear to be in accordance with ODG guidelines

NCV TO THE LOWER EXTREMITIES: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines INTERFERENTIAL CURRENT STIMULATION Page(s): 117-119, 121.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

Decision rationale: The patient presents with lower back pain, right foot plantar fasciitis and numbness in both feet. I have been asked to review for NCV bilateral lower extremities. MTUS/ACOEM states: "Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks." The patient's back pain has been present over 4-weeks. The right plantar fasciitis may explain some of the right foot pain, but there were subjective complaints of numbness in the right and left feet. H-reflex is a part of the NCV. The request for the NCV BLE appears to be in accordance with MTUS/ACOEM guidelines