

<b>Case Number:</b>	CM13-0002448		
<b>Date Assigned:</b>	12/11/2013	<b>Date of Injury:</b>	02/26/2007
<b>Decision Date:</b>	01/13/2014	<b>UR Denial Date:</b>	07/08/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/22/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Pain Management, has a subspecialty in Disability Evaluation, 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 physician 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.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

Per medical records reviewed, the patient is a 69 year old female who was injured on 2/26/2007. The injury occurred when she was helping children and fell and injured multiple body parts including her neck. Patient was evaluated by orthopedic surgeon, [REDACTED] on 10/14/13 for complaint of neck pain with radiation to bilateral upper extremities associated with numbness. Examination by [REDACTED] revealed that the cervical range of motion showed 40 degrees of flexion, 35 degrees of extension, 25 degrees of right bending, 20 degrees of left bending, 70 degrees of right rotation, and 60 degrees of left rotation. [REDACTED] reported paracervical guarding. Strength was 5 on a scale of 5 in the neck and upper extremities and sensation was intact. Reflexes were normal. [REDACTED] recommended MRI of the cervical spine without contrast because of the discrepancies in two previous MRIs. Diagnosis of 1) Cervical strain with left upper extremity C7 cervical radiculitis with uncovertebral hypertrophic spurring, mild central canal stenosis and mild bilateral foraminal stenosis at the C3-4 level on MRI scanning of the cervical spine performed at California Imaging Network on May 3, 2013 and read by radiologist, [REDACTED]. 2) Lumbar degenerative facet joint disease L4 to S1 with moderate to severe bilateral foraminal stenosis at the L5-S1 level and right, greater than left, lower extremity S1 lumbar radiculitis.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**EMG of the bilateral lower extremities (BLE):** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

**Decision rationale:** According to Occupational Medicine Practice Guidelines, page 178, physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies 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. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. The assessment may include sensory-evoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected. If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps, including the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, compute tomography [CT] for bony structures). Additional studies may be considered to further define problem areas. The recent evidence indicates cervical disk annular tears may be missed on MRIs. The clinical significance of such a finding is unclear, as it may not correlate temporally or anatomically with symptoms. According to [REDACTED], a neurosurgeon medical report a diagnosis of Cervicalgia with upper extremity non-verifiable radicular complaints and Low back pain with lower extremity radicular complaints. [REDACTED] requested for EMG studies of bilateral lower extremities to help identify any potential subclinical radiculopathy. This reviewer believes that request for EMG of the bilateral lower extremities (BLE) was medically necessary based on the facts presented above.

**NCV of the bilateral lower extremities (BLE):** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

**Decision rationale:** According to Occupational Medicine Practice Guidelines, page 178, physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies 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. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. The assessment may include sensory-

evoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected. If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps, including the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, compute tomography [CT] for bony structures). Additional studies may be considered to further define problem areas. The recent evidence indicates cervical disk annular tears may be missed on MRIs. The clinical significance of such a finding is unclear, as it may not correlate temporally or anatomically with symptoms. According to [REDACTED], a neurosurgeon medical report a diagnosis of Cervicalgia with upper extremity non-verifiable radicular complaints and Low back pain with lower extremity radicular complaints. [REDACTED] requested for NCV studies of bilateral lower extremities to help identify any potential subclinical radiculopathy. This reviewer believes that request for NCV of the bilateral lower extremities (BLE) was medically necessary based on the facts presented above

#### **EMG of the bilateral upper extremities (BUE): Overturned**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

**Decision rationale:** According to Occupational Medicine Practice Guidelines, page 178, physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies 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. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. The assessment may include sensory-evoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected. If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps, including the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, compute tomography [CT] for bony structures). Additional studies may be considered to further define problem areas. The recent evidence indicates cervical disk annular tears may be missed on MRIs. The clinical significance of such a finding is unclear, as it may not correlate temporally or anatomically with symptoms. According to [REDACTED], a neurosurgeon medical report a diagnosis of Cervicalgia with upper extremity non-verifiable radicular complaints and Low back pain with lower extremity radicular complaints. [REDACTED] requested for EMG studies of bilateral upper extremities to help identify any potential subclinical radiculopathy. This reviewer believes that request for EMG of the bilateral upper extremities (BUE) was medically necessary based on the facts presented above

#### **NCV of the bilateral upper extremities (BUE): Overturned**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

**Decision rationale:** According to Occupational Medicine Practice Guidelines, page 178, physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies 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. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. The assessment may include sensory-evoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected. If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps, including the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, compute tomography [CT] for bony structures). Additional studies may be considered to further define problem areas. The recent evidence indicates cervical disk annular tears may be missed on MRIs. The clinical significance of such a finding is unclear, as it may not correlate temporally or anatomically with symptoms. According to [REDACTED], a neurosurgeon medical report a diagnosis of Cervicalgia with upper extremity non-verifiable radicular complaints and Low back pain with lower extremity radicular complaints. [REDACTED] requested for NVC studies of bilateral upper extremities to help identify any potential subclinical radiculopathy. This reviewer believes that request for NCV of the bilateral upper extremities (BUE) was medically necessary based on the facts presented above

**MRI of the lumbar spine:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

**Decision rationale:** According to Occupational Medicine Practice Guidelines, page 178, physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies 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. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm

symptoms, or both, lasting more than three or four weeks. The assessment may include sensory-evoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected. If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps, including the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, compute tomography [CT] for bony structures). Additional studies may be considered to further define problem areas. The recent evidence indicates cervical disk annular tears may be missed on MRIs. The clinical significance of such a finding is unclear, as it may not correlate temporally or anatomically with symptoms. According to [REDACTED], a neurosurgeon medical report a diagnosis of Cervicalgia with upper extremity non-verifiable radicular complaints and Low back pain with lower extremity radicular complaints. [REDACTED] requested for MRI of the lumbar spine to help identify any potential subclinical radiculopathy. This reviewer believes that request for an MRI of the lumbar spine was medically necessary based on the facts presented above

### **MRI of the cervical spine:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

**Decision rationale:** According to Occupational Medicine Practice Guidelines, page 178, physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies 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. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. The assessment may include sensory-evoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected. If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps, including the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, compute tomography [CT] for bony structures). Additional studies may be considered to further define problem areas. The recent evidence indicates cervical disk annular tears may be missed on MRIs. The clinical significance of such a finding is unclear, as it may not correlate temporally or anatomically with symptoms. According to [REDACTED], a neurosurgeon medical report a diagnosis of Cervicalgia with upper extremity non-verifiable radicular complaints and Low back pain with lower extremity radicular complaints. [REDACTED] requested for MRI of the cervical spine to help identify any potential subclinical radiculopathy. This reviewer believes that request for an MRI of the cervical spine was medically necessary based on the facts presented above