

Case Number:	CM13-0006303		
Date Assigned:	12/27/2013	Date of Injury:	04/22/2013
Decision Date:	06/13/2014	UR Denial Date:	07/18/2013
Priority:	Standard	Application Received:	08/02/2013

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 Neuromusculoskeletal Medicine and is licensed to practice in Arizona. 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 Hispanic female with history of a "work related injury" as result of repetitive motion trauma of her neck occurred on April 4-22, 2013 who reports of right cervical pain, pain in the right shoulder, elbow and wrist . Additionally, the patient reports 8/10 pain on the 1-10 pain scale that is described as stabbing, throbbing that is severe in severity that is aggravated by all planes of normal inherent motion of the cervical spine and causing difficulty in sleeping. Physical exam findings of the cervical spine include tenderness on the right at the C3-7 levels with reduction in range of motion in all planes of motion; deep tendon reflex and motor strength of bilateral upper extremities 'within normal limits'. Sensory exam revealed decreased touch and pinpoint in the right upper extremity along the C7 dermatome. Spurling test documented as positive on the right (elbow). Right extremity grip strength decreased when compared to the left. Plain radiographs reports "small cervical ribs' without documenting which cervical level visualized and limited range of motion on flexion / extension views. Her initial pain management eval dated June 4, 2013 documents that she has occasional lower back pain with radiation of the right lower extremity to the level of the knee, calf and foot with associated numbness in the right lower extremity Her physical exam findings include Spinal vertebral tenderness on the right in the lumbar spine with tenderness on the right buttock upon palpation. There is noted decreased range of motion in all planes of motion with normal findings for reflex's, motor functioning and sensory testing of distal lower extremity and a negative seated and lying straight leg raise with patient able to heel and toe walk without foot drop and absence of clonus. Plain radiography dated 7/02/2013 identifies a Grade II anterolisthesis at L5-S1 with suspected bilateral pars defect and osteophyte formation along the right aspect of the spine at L1-L2. In dispute is the obtainment of right lower extremity nerve conduction and electromyography (EMG) studies.

IMR ISSUES, DECISIONS AND RATIONALES

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

ELECTROMYOGRAPHY (EMG) OF THE RIGHT LOWER EXTREMITY, AS OUTPATIENT: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, Cervical and Thoracic Spine.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303,309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Electrodiagnostic studies (EDS).

Decision rationale: EMG studies are recommended as an option for low back pain may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. Electrodiagnostic studies should be performed by appropriately trained Physical Medicine and Rehabilitation or Neurology physicians. EMG testing should be medically indicated (i.e., to rule out radiculopathy, lumbar plexopathy, peripheral neuropathy) and not utilized for screening purposes. As the patient expresses a history of distal extremity numbness, tingling her physical examination does not delineate distal neurological dysfunctioning. As the physical examination does not support the patient's subjective claims of right lower extremity radiculopathy, the test is not medically necessary.

NERVE CONDUCTION STUDY OF THE RIGHT LOWER EXTREMITY, AS OUTPATIENT: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, Cervical and Thoracic Spine.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Electrodiagnostic studies (EDS).

Decision rationale: The Official Disability Guidelines states Nerve Conduction Velocity (NCV) Studies are "Not recommended except for evaluating patients who've suffered a spinal cord injured (SCI) that meet ALL of the following criteria: intact lower motor units (L1 and below) (both muscle and peripheral nerve), muscle and joint stability for weight bearing at upper and lower extremities that can demonstrate balance and control to maintain an upright support posture independently, able to demonstrate brisk muscle contraction to NMES and have sensory perception of electrical stimulation sufficient for muscle contraction, possess high motivation, commitment and cognitive ability to use such devices for walking, have demonstrated a willingness to use the device long-term, ability to transfer independently and can demonstrate independent standing tolerance for at least three minutes, ability to demonstrate hand and finger function to manipulate controls, having at least six-month post recovery spinal cord injury and

restorative surgery and no hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis. As the patient does not have a history of spinal cord injury, trauma, infection or vertebral fracture leading to compromise of the spinal cord, the request for a NCV has no merit and is therefore not medically indicated.