

<b>Case Number:</b>	CM13-0008831		
<b>Date Assigned:</b>	09/11/2013	<b>Date of Injury:</b>	07/30/1997
<b>Decision Date:</b>	01/29/2014	<b>UR Denial Date:</b>	07/27/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/07/2013

### 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 Physical Medicine and 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. 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:

The underlying date of injury in this case is 07/30/1997. An initial physician review notes that this patient has been evaluated for left-sided neck and arm pain and numbness more so than right-sided symptoms, and the patient has also reported low back pain, left hip pain, and left upper thigh pain. As of 07/11/2013, the patient was noted to have normal strength, normal reflexes, and no sensory deficits. The prior reviewer notes that the patient previously underwent electrodiagnostic studies of the lower extremity which was unremarkable as of 01/15/2013. Overall the prior reviewer concluded that the medical records did not establish the medical necessity for electrodiagnostic studies. An MRI of the cervical spine on 03/12/2013 demonstrated mild spinal stenosis and moderate to severe left foraminal stenosis at C5-C6 encroaching upon the left C6 nerve root. An authorization request form via a handwritten fax of 05/14/2013 refers to an office visit note in which the physician recommended electrodiagnostic studies of the bilateral lower extremities as well as a neck injection. That note reviews the patient's history of an L5-S1 fusion in 2008 and ongoing symptoms of neck and back pain, left greater than right. On examination, the patient had pain in the C6 distribution bilaterally. CT imaging demonstrated a solid fusion at L5-S1. MRI imaging of the cervical spine demonstrated mild degenerative changes without any significant central or foraminal narrowing and a very tiny syrinx of unknown significance. The patient's strength was intact. The treating physician recommended electrodiagnostic studies to evaluate for a neuropathy versus compressive radicular etiology of the upper or lower extremities.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**EMG/NCV of the bilateral upper and lower extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 10 Elbow Disorders (Revised 2007), Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 33; 178; 212; 261; 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain.

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

**Decision rationale:** The ACOEM Guidelines, Chapter 8 Neck, page 178, states, "Electromyography and nerve conduction velocities may help identify subtle focal and neurological dysfunction in patients with neck or arm symptoms or both lasting more than 3 or 4 weeks." Similarly, ACOEM Guidelines, Chapter 12 Low Back, page 303, states, "Electromyography, including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks." These guidelines discuss indications for electrodiagnostic testing versus imaging, but those guidelines do not provide a basis for both electrodiagnostic studies and imaging or basis for electrodiagnostic studies and followup imaging, as has been requested in this case. Most notably, the medical records at this time do not clearly document a differential diagnosis in terms of what root level or what peripheral nerve pathology would be suspected. Therefore, an electrodiagnostic study could produce a false positive diagnosis. Overall the medical records do not provide a clear rationale or differential diagnosis to support the requested study. The request for EMG and NCV of the bilateral upper and lower extremities is not medically necessary and appropriate.