

<b>Case Number:</b>	CM13-0027073		
<b>Date Assigned:</b>	11/22/2013	<b>Date of Injury:</b>	09/26/2008
<b>Decision Date:</b>	02/28/2014	<b>UR Denial Date:</b>	08/08/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/20/2013

### 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 Rehabilitation, has a subspecialty in Neuromuscular Medicine, and is licensed to practice in Maryland. 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:

This 61-year-old male was injured 09/26/08 and had a continuous trauma injury from 01/22/09 through 09/07/09. On 6/20/13 note by [REDACTED] states that the patient has had continued symptomatology. At this point in time, due to the failure of conservative measures, which include activity modification, physical therapy and pain management, recommendation for surgical intervention will be made in the form of C4 to C7 anterior cervical microdiscectomy with implantation of hardware and realignment of the significant junctional kyphotic deformity that is present. Additionally he requested MRI of the cervical spine and EMG (electromyogram) of the BUE (nilateral upper extremities) and BLE (bilateral lower extremities). Whether or not they are medically necessary will be addressed in this review. November 13, 2009 - Summary Of EMG Findings - Impression - Moderate-to-severe peripheral neuropathy.. This is most probable related to the patient's history of diabetes; Possible severe carpal tunnel syndrome, with relatively worse latencies of the median motor nerves compared' to the ulnar motor nerves and absent responses in the median sensory nerves. 09/07/10 Electrodiagnostic studies of the upper and lower extremities. Impression: 1) Normal EMG; 2) The NCS shows findings of severe peripheral polyneuropathy secondary to generalized systemic neuropathic process such as diabetes. 09/30/10 MRI of the cervical spine: Impression: 1) There is a 3 mm disc protrusion at C3-4; 2) There is a 5 mm disc protrusion at C4-5, causing mild C4-5 spinal canal stenosis; 3) There is a 3 mm disc protrusion at C5-6; 4) There is a 1 to 2 mm disc protrusion at C6-7. 9/30/10 MRI-of-the-Lumbosacral-spine Impression: 1) There is a 5 mm spondylolisthesis, L5 on S 1, with 4 mm bilateral intraforaminal disc protrusion and disc space narrowing; 2) -There is a 3 mm disc protrusion at L2-3; 3) There is a 1 to 2 mm disc protrusion at L3-4 and L4-5 10/06/10 MRI of the left shoulder. This shows a massive, full thickness rotator cuff tear with superior migration of the humeral head. There is complete retraction of the rotator cuff, including the supraspinatus and subscapularis. 2/10/10 Left carpal tunnel release. 8/29/13 Office note

indicates that: The patient has persistent pain of the low back that is aggravated with usual activities. He has neck pain that is aggravated by repetitive motions of the neck / prolonged positioning of the neck, pushing, pulling, lifting, forward reaching, and working at or above the shoulder level. The symptomatology in the patient's bilateral shoulders and left wrist is essentially unchanged. **PHYSICAL EXAMINATION (Objective): CERVICAL SPINE:** Examination of the cervical spine reveals tenderness at the cervical paravertebral muscles and upper trapezial muscles with spasm. There is pain with terminal motion. **BILATERAL SHOULDERS:** Examination of the bilateral shoulders is essentially unchanged. There is tenderness at the subacromial space and acromioclavicular joint. There is a positive Hawkins' and impingement sign. There is limited range of motion and weakness of the shoulder, left greater than right. **LEFT WRIST:** Examination of the left wrist is essentially unchanged. There are positive Tinel's and Phalen's signs. There is a well-healed left carpal tunnel release scar. There is tenderness at the volar aspect of the left wrist. There is pain with terminal flexion. **LUMBAR SPINE:** Examination of the lumbar spine reveals tenderness at the lumbar paravertebral muscles; There is pain with terminal motion. Seated nerve root test is positive. There is dysesthesia at the L5 and S1 dermatomes. 7/18/13 **PHYSICAL EXAMINATION (Objective): CERVICAL SPINE-** Examination of the cervical spine reveals tenderness at the cervical paravertebral muscles and upper trapezial muscles with spasm. Axial loading compression test and Spurling's maneuver are positive. There is painful and restricted cervical range of motion. There is dysesthesia at the C5 to

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Cervical MRI:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck Chapter, MRI Section.

**Decision rationale:** The Physician Reviewer's decision rationale: Cervical MRI is medically necessary per ACOEM Practice Guidelines and ODG guidelines. According to the Neck and Upper Back Complaints Chapter of the ACOEM Practice Guidelines, "to validate diagnosis of nerve root compromise, based on clear history and physical examination findings, in preparation for invasive procedure." According to the ODG , "Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation). (Anderson, 2000) (ACR, 2002)." According to documentation patient had a cervical MRI on 9/30/10 . The physical exam findings have changed since this imaging with evidence of radicular symptoms on provocative testing and dyesthesias in the C5-7 dermatomes. Recommendations are made for cervical surgery. Therefore, the request for a cervical MRI is medically necessary and appropriate.

**Bilateral upper and lower EMG/NCV (electromyogram/ nerve conduction velocity test):**  
Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 308-309.

**Decision rationale:** The Physician Reviewer's decision rationale: BUE and BLE EMG/NCV is medically necessary per MTUS guidelines. According to recent physical exam patient has a positive seated nerve root test in the lower extremities. "Seated nerve root test is positive. There is dysesthesia at the L5 and S1 dermatomes." Electrodiagnostic testing (EMG/NCS) of the BUE and BLE extremities is medically necessary. EMG/NCS of the upper extremities and lower extremities is medically reasonable to clarify nerve root dysfunction. Patient has a history of peripheral polyneuropathy on prior testing (which was in 2010) possibly secondary to diabetes mellitus. It is not unreasonable to evaluate the BUE and BLE through electrodiagnostic study to clarify whether the dysesthesias in the BLE are from lumbar radiculopathy vs. peripheral polyneuropathy. Additionally, the upper extremities NCS/EMG can evaluate whether patient's symptoms are secondary to peripheral polyneuropathy vs entrapment/compression neuropathy or radiculopathy. This is particularly important in the BUE due to plans of upcoming cervical surgery. The request for a bilateral upper and lower EMG/NCV is medically necessary and appropriate.