

Case Number:	CM13-0030881		
Date Assigned:	04/25/2014	Date of Injury:	11/09/1994
Decision Date:	07/04/2014	UR Denial Date:	09/10/2013
Priority:	Standard	Application Received:	10/02/2013

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 Neurology, has a subspecialty in Neuromuscular Medicine 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:

The patient is a 64-year-old man, who sustained a work-related injury on November 9, 1994. Subsequently, the patient developed chronic neck and left shoulder pain. He was diagnosed with cervical radiculopathy and chronic pain. His MRI of the cervical spine dated on April 19, 2012 indicated possible root impingement upon the C5-6 root. His electromyography/nerve conduction velocity (EMG/NCV) of April 20, 2012, showed bilateral C6-7 cervical radiculopathy. According to a note dated on August 15, 2013, the patient was complaining of chronic neck and back pain with worsening of left upper extremity numbness and weakness. His physical examination showed cervical tenderness with reduced range of motion, and decreased touch in the left upper extremity. The provider requested authorization for another NCV and EMG study of both upper extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

ELECTROMYOGRAPHY (EMG) OF THE BILATERAL UPPER EXTREMITIES:

Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation NECK AND UPPER BACK

COMPLAINTS CHAPTER (ACOEM PRACTICE GUIDELINES, 2ND EDITION (2004), CHAPTER 8) PAGE 178, 179, AND 182; AND FOREARM, WRIST, AND HAND COMPLAINTS CHAPTER (ACOEM PRACTICE GUIDELINES, 2ND EDITION (2004), CHAPTER 11) PAGE 269.

Decision rationale: The MTUS/ACOEM Guidelines indicate that "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." EMG has the excellent ability to identify abnormalities related to disc protrusion. The guidelines also indicate that needle EMG study helps identify subtle neurological focal dysfunction in patients with neck and arm symptoms. When the neurologic examination is less clear, 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 (3) or four (4) weeks. An EMG is indicated to clarify nerve dysfunction in case of suspected disc herniation. An EMG is useful to identify physiological insult and anatomical defect in case of neck pain and back pain. In addition, the guidelines indicate that EMG/NCV testing have low ability to identify wrist and forearm pathology except for carpal tunnel syndrome. The patient was already diagnosed with cervical radiculopathy and three (3) level fusion has already been recommended. There is no documentation of dramatic change in the patient symptoms and signs that suggest an alternative or superimposed diagnosis to the already diagnosed radiculopathy. Therefore, the request for electromyography (EMG) of the bilateral upper extremities is not medically necessary.

NERVE CONDUCTION VELOCITY (NCV) STUDY OF THE BILATERAL UPPER EXTREMITIES: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation NECK AND UPPER BACK COMPLAINTS CHAPTER (ACOEM PRACTICE GUIDELINES, 2ND EDITION (2004), CHAPTER 8) PAGE 178, 179, AND 182; AND FOREARM, WRIST, AND HAND COMPLAINTS CHAPTER (ACOEM PRACTICE GUIDELINES, 2ND EDITION (2004), CHAPTER 11) PAGE 269.

Decision rationale: The MTUS/ACOEM Guidelines indicate that "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." EMG has the excellent ability to identify abnormalities related to disc protrusion. The guidelines also indicate that needle EMG study helps identify subtle neurological focal dysfunction in patients with neck and arm symptoms. When the neurologic examination is less clear, 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

(3) or four (4) weeks. An EMG is indicated to clarify nerve dysfunction in case of suspected disc herniation. An EMG is useful to identify physiological insult and anatomical defect in case of neck pain and back pain. In addition, the guidelines indicate that EMG/NCV testing have low ability to identify wrist and forearm pathology except for carpal tunnel syndrome. The patient was already diagnosed with cervical radiculopathy and three (3) level fusion has already been recommended. There is no documentation of dramatic change in the patient symptoms and signs that suggest an alternative or superimposed diagnosis to the already diagnosed radiculopathy. Therefore, the request for nerve conduction velocity (NCV) study of the bilateral upper extremities is not medically necessary.