

Case Number:	CM13-0039844		
Date Assigned:	12/20/2013	Date of Injury:	09/01/2006
Decision Date:	06/05/2014	UR Denial Date:	09/30/2013
Priority:	Standard	Application Received:	10/09/2013

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 sustained a work related injury on September 1 2006. Subsequently he developed chronic neck pain. He underwent a cervical laminectomy. The patient was diagnosed with the radiculitis, disc displacement, headaches and cervical disc degeneration. The patient was treated to with the physical therapy pain medications ice and heat and cervical fusion. His cervical MRI performed on March 28, 2012 demonstrated disc bulging at C2-C3 C3-C4 and C4-C5. The patient underwent an EMG nerve conduction studies performed on may 20/4/2012 which demonstrated cervical radiculopathy at the left C7 C8, left carpal tunnel syndrome and left cubital tunnel syndrome. At that time the patient was complaining of left side neck pain radiating to the shoulder and arm and associated with numbness and weakness of the arm and fingers. According to a note dated on September 12, 2013, the patient was suffering of chronic neck pain. His physical examination demonstrated cervical tenderness with reduced range of motion and reduced sensation in the territory of C5-C6 dermatome. The patient was treated with the Prilosec all from Neurontin Percocet and Skelaxin. The provider requested authorization for an EMG nerve conduction study of both upper extremities because of worsening of symptoms of radiculopathy.

IMR ISSUES, DECISIONS AND RATIONALES

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

ELECTROMYOGRAPHY OF THE BILATERAL UPPER EXTREMITIES: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 178-179, 182, 303-304.

Decision rationale: According to MTUS guidelines (MTUS page 303 from ACOEM guidelines), 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 excellent ability to identify abnormalities related to disc protrusion (MTUS page 304 from ACOEM guidelines). According to MTUS guidelines, needle EMG study helps identify subtle neurological focal dysfunction in patients with neck and arm symptoms. 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 (page 178). EMG is indicated to clarify nerve dysfunction in case of suspected disc herniation (page 182). EMG is useful to identify physiological insult and anatomical defect in case of neck pain and back pain (page 179). In addition and according to MTUS guidelines, table 11.6, 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. 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 Bilateral Upper Extremities is not medically necessary and appropriate.

NERVE CONDUCTION VELOCITY STUDY OF THE BILATERAL UPPER EXTREMITIES: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 178-179, 182, 303-304.

Decision rationale: According to MTUS guidelines (MTUS page 303 from ACOEM guidelines), 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 excellent ability to identify abnormalities related to disc protrusion (MTUS page 304 from ACOEM guidelines). According to MTUS guidelines, needle EMG study helps identify subtle neurological focal dysfunction in patients with neck and arm symptoms. 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 (page 178). EMG is indicated to clarify nerve dysfunction in case of suspected disc

herniation (page 182). EMG is useful to identify physiological insult and anatomical defect in case of neck pain and back pain (page 179). In addition and according to MTUS guidelines, table 11.6, 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. 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 study of the bilateral upper extremities is not medically necessary and appropriate.