Case Number:	CM13-0071029		
Date Assigned:	01/08/2014	**Date of Injury:**	07/02/2012
Decision Date:	06/05/2014	**UR Denial Date:**	12/12/2013
Priority:	Standard	**Application Received:**	12/26/2013

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 Occupational 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 an employee of [redacted] and has submitted a claim for chronic myofascial pain syndrome of the cervical and thoracolumbar spine, mild bilateral L5 radiculopathy, and cervical radiculopathy versus peripheral nerve entrapment associated with an industrial injury date of July 2, 2012. Treatment to date has included trigger point injections, acupuncture, home exercise program, and medications such as Tramadol, Norco, Xanax, Naproxen, Topical Analgesics, and Clobenzaprine. Medical records from 2012 to 2013 were reviewed showing that patient complained of frequent neck, upper, and lower back pain that has varied from 6 to 8/10 in severity. Intake of medications provided 60% pain improvement. He likewise complained of frequent pain and numbness in his right arm and intermittent numbness on both hands. This resulted to moderate difficulty in his general activities and enjoyment of life, but with severe difficulty in his ability to concentrate and interact with other people. He likewise complained of difficulty in sleeping and feelings of depression and anxiety. Physical examination showed multiple myofascial trigger points throughout the cervical paraspinal, trapezius, levator scapulae, scalene, infraspinatus muscles, thoracic and lumbar paraspinal muscles, and gluteal muscles. Range of motion of the cervical spine was slightly restricted on all planes. Range of motion of the thoracolumbar spine was slightly to moderately restricted on all planes. Romberg sign was negative. He could not perform heel- and toe-gait well with the right leg or foot. Muscle strength was grossly intact throughout the upper and lower extremities. Deep tendon reflexes were equal and symmetric. Sensation was diminished at the third and fourth digits of the left hand, as well as in the second, third, and fourth digits of the right hand, in addition to the lateral aspect of the right forearm. Sensation was likewise decreased in the lateral aspect of the right calf and in the dorsum of the foot. MRI of the cervical spine, dated February 27, 2013, revealed early desiccation at C2-C3 to C5 to C6 levels. At C3 to C4 and C6-C7, there

was diffuse disk protrusion effacing the thecal sac; while C4-C5, and C5-C6 showed focal central disk protrusion. Exiting nerve roots were unremarkable. EMG/NCV (electromyogram and nerve conduction velocity) of bilateral upper extremities, dated March 25, 2013, revealed electrophysiologic evidence of left mild carpal tunnel syndrome and right moderate carpal tunnel syndrome; without acute or chronic denervation potentials in any of the muscles tested. Utilization review from December 12, 2013 denied the requests for NCV of right upper extremity, EMG of left upper extremity, NCV of the left upper extremity, and EMG of right upper extremity because it is not clear as to what specific diagnoses is trying to be ruled out and how all these studies will be helpful in the overall treatment plan. It is likewise not clear whether any previous upper extremity elecrodiagnostic testing has been done since the work injury.

IMR ISSUES, DECISIONS AND RATIONALES

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

(NCV) NERVE CONDUCTION VELOCITY OF THE RIGHT UPPER EXTREMITY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

Decision rationale: Forearm, Wrist, and Hand Complaints ACOEM guidelines state that appropriate electrodiagnostic studies may help differentiate between carpal tunnel syndrome and other conditions, such as cervical radiculopathy. These include nerve conduction studies, or in more difficult cases, electromyography may be helpful. In this case, the patient has been complaining of persistent neck pain radiating to the right arm with intermittent numbness on both hands. Physical examination showed normal motor strength and reflexes for both upper extremities, however, sensation was diminished at the third and fourth digits of the left hand, as well as in the second, third, and fourth digits of the right hand, and lateral aspect of right forearm. MRI of the cervical spine, dated February 27, 2013, revealed multi-level early desiccation and disk protrusion without compression of exiting nerves. The rationale given for this reque st is because of worsening pain and numbness of right arm and both hands which may be due to cervical radiculopathy versus peripheral nerve entrapment. However, EMG/NCV of bilateral upper extremities was already accomplished on March 25, 2013, confirming electrophysiologic evidence of left mild carpal tunnel syndrome and right moderate carpal tunnel syndrome; with normal EMG findings. It is not clear due to lack of documentation on what additional information is needed for a repeat EMG/NCV and how it will affect treatment plans. Therefore, the request for NCV of the right upper extremity is not medically necessary.

(EMG) ELECTROMYOGRAM OF THE LEFT UPPER EXTREMITY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 537.

Decision rationale: Neck and Upper Back Complaints ACOEM guidelines state that electromyography (EMG) studies may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. In this case, the patient has been complaining of persistent neck pain radiating to the right arm with intermittent numbness on both hands. Physical examination showed normal motor strength and reflexes for both upper extremities, however, sensation was diminished at the third and fourth digits of the left hand, as well as in the second, third, and fourth digits of the right hand, and lateral aspect of right forearm. MRI of the cervical spine, dated February 27, 2013, revealed multi-level early desiccation and disk protrusion without compression of exiting nerves. The rationale given for this request is because of worsening pain and numbness of right arm and both hands which may be due to cervical radiculopathy versus peripheral nerve entrapment. However, EMG/NCV of bilateral upper extremities was already accomplished on March 25, 2013, confirming electrophysiologic evidence of left mild carpal tunnel syndrome and right moderate carpal tunnel syndrome; with normal EMG findings. It is not clear due to lack of documentation on what additional information is needed for a repeat EMG/NCV and how it will affect treatment plans. Therefore, the request for EMG of the left upper extremity is not medically necessary.

(NCV) NERVE CONDUCTION VELOCITY OF THE LEFT UPPER EXTREMITY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

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