Case Number:	CM14-0007111		
Date Assigned:	02/07/2014	**Date of Injury:**	05/20/2012
Decision Date:	06/23/2014	**UR Denial Date:**	12/20/2013
Priority:	Standard	**Application Received:**	01/15/2014

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, and is licensed to practice in Texas. 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 injured worker is a a 37-year-old male who reported an injury on May 20, 2012. The worker was injured when he hit his head on the right side. The clinical note dated November 19, 2013 reported the injured worker complained of the feeling of a knot or ball in the left hand, left small pinky, left shoulder, and scapula. The injured worker reported having pain 80% in the neck and 20% in the arm. The injured worker rated his pain 6/10 in the neck with constant shoulder spasms to the left shoulder and interscapular region. The injured worker previously underwent a C6-7 anterior cervical fusion in January of 2013. Upon physical examination, the provider noted the injured worker to showed rotation to the right arm was 50 to 60 degrees and left arm was 70 to 80 degrees. The provider also noted extension of the arms was 50 to 60 degrees. The provider noted flexion of the arms was 70 to 80 degrees. The provider noted left forearm, thumb, index, and ulnar small finger sensory loss. The injured worker had diagnoses of status post C6-7 discectomy, residual C6-7 foraminal stenosis, recurrent C5-6 herniation, and left shoulder bursitis. The injured worker has undergone physical therapy, discectomy, physical therapy post operative with no improvement in his symtoms.The provider requested an EMG/NCV of the bilateral upper extremities to rule out peripheral neuropathy. The Request for Authorization was submitted on December 16, 2013.

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181-183. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & upper Back, Electromyography (EMG).

Decision rationale: The injured worker complained of a sensation of knot or ball in the left hand, left small pinky, and left shoulder and scapula. The injured worker reported having pain 80% in the neck and 20% in the arm. The injured worker rated pain 6/10. The injured worker reported constant shoulder spasm in the left shoulder and interscapular region. The Neck and Upper Back Complaints Chapter of the ACOEM Practice Guidelines state unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. 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. The Official Disability Guidelines note while cervical electrodiagnostic studies are not necessary to demonstrate a cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality or some problem other than a cervical radiculopathy, but these studies can result in unnecessary over treatment. The clinical documentation submitted indicated the injured worker had left-sided symptoms including forearm, thumb, index, and ulnar small finger sensory loss. There is a lack of documentation indicating the injured worker to have had any neruological deficits in the right extremity. There is a lack of documentation indicating the injured workers need for a bilateral electrodiagnostic study. The request for an EMG of the bilateral upper extremities is not medically necessary or appropriate.

NERVE CONDUCTION STUDIES (NCS) 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 8 Neck and Upper Back Complaints Page(s): 177-179. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & upper Back, Nerve conduction studies (NCS).

Decision rationale: The injured worker reported the sensation of a knot or a ball in his left hand, left small pinky, left shoulder and scapula. The injured worker reported pain 80% in the neck and 20% in the arm. The injured worker rated his pain at 6/10. The injured worker reported constant shoulder spasms in the left shoulder and interscapular region. The Neck and Upper Back Complaints Chapter of the ACOEM Practice Guidelines state unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. 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. The Official Disability Guidelines do not recommend a nerve conduction study to demonstrate radiculopathy if radiculopathy has already been clearly identified by an EMG and obvious clinical signs, but is recommended if the EMG does not clearly state radiculopathy or is clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely, based on the clinical exam. There is a lack of documentation indicating the need for a bilateral upper extremities nerve conduction study. The documentation provided indicated the injured worker to have only left forearm, thumb, index, and ulnar small finger sensory loss. There is a lack of documentation indicating the injured worker to have had any neurological deficits in the right extremity. There is lack of objective findings warranting the request for a bilateral NCS. Additionally, it was unclear why an NCV would be needed in addition to an EMG. The request for an NCS of the bilateral upper extremities is not medically necessary or appropriate.