Case Number:	CM14-0128523		
Date Assigned:	08/15/2014	**Date of Injury:**	01/21/2009
Decision Date:	10/02/2014	**UR Denial Date:**	07/28/2014
Priority:	Standard	**Application Received:**	08/12/2014

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 Physical Medicine & 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 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 38 year old female with a work injury dated 12/29/09.The diagnoses include status post anterior cervical discectomy and fusion at C5-C6 and C6-C7 in 2012 with residual symptoms.2. Cervical radiculitis.3. Left elbow lateral epicondylitis.4. Left shoulder strain.A 1/21/14 AME states that the patient presents with history of two level cervical disk bulge and stenosis treated with anterior discectomy and fusion and has residual symptoms. The preoperative MRI and postoperative MRI both document spinal cord signal abnormality with myelomalacia. The medical records include report of well incorporated anterior fusion with no sign of implant complication or loosening with radiographic evidence of fusion dated January 7, 2013. The medical records also document normal EMG nerve conduction study of the bilateral upper extremities prior to her surgery. A cervical MRI report dated 1/17/12 described minimal/mild degenerative disc disease at C5-6 and C6-7 with diffuse disc bulging and osteophytic spurring. There was a small focus of myelomalacia at C5-6.A 7/3/14 document states that the patient continues to have neck pain radiating into the left upper extremity with numbness/tingling and weakness. There is a request for updated neurodiagnostic studies of the bilateral upper extremities to be performed in order to further evaluate the patient's radiculopathy since she continues to be symptomatic postoperatively. On exam there is spasm, tenderness, and guarding is noted in the paravertebral muscles of the cervical spine with decreased range of motion. Decreased dermatomal sensation with pain is noted over the left C6 dermatome. A well-healed incision is noted over the operative site A 1/22/14 document states that given that there are no additional surgical interventions being contemplated, it is the documenting physician's opinion that the patient is approaching maximum medical improvement.The documentation

indicates that the patient was having pain radiating pain and numbness into L arm, shoulder and forearm, tingling in ulnar left hand.

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.

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

Decision rationale: Electromyography (EMG) of the bilateral upper extremities is not medically necessary per the MTUS ACOEM Guidelines. The ACOEM guidelines state that when the neurologic examination is less clear, further physiologic evidence of nerve dysfunction can be obtained. 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-neck complaints . The documentation indicates that the patient has had chronic left upper extremity symptoms. There is no discussion of right upper extremity symptoms. The documentation indicates that no further surgery is planned therefore it is not clear how the electromyography (EMG) of the bilateral upper extremities would change the patient's management. The request for electromyography (EMG) of the bilateral upper extremities is therefore not medically necessary.

Nerve Conduction Velocity Tests (NCV) of the bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

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

Decision rationale: Nerve conduction velocity tests (NCV) of the bilateral upper extremities is not medically necessary per the MTUS ACOEM Guidelines. The ACOEM guidelines state that when the neurologic examination is less clear, further physiologic evidence of nerve dysfunction can be obtained. 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-neck complaints . The documentation indicates that the the patient has had chronic left upper extremity symptoms. There is no discussion of right upper extremity symptoms. The documentation indicates that no further surgery is planned therefore it is not clear how the nerve conduction velocity tests of the bilateral upper extremity would change the pateint management. The request, therefore for nerve conduction velocity Tests (NCV) of the bilateral upper extremities is not medically necessary.