

<b>Case Number:</b>	CM14-0161892		
<b>Date Assigned:</b>	10/07/2014	<b>Date of Injury:</b>	05/17/2006
<b>Decision Date:</b>	12/11/2014	<b>UR Denial Date:</b>	09/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/02/2014

### 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 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:

This is a 47-year-old female with a 5/17/06 date of injury. The mechanism of injury occurred when she lifted a patient onto a gurney and experienced the onset of neck, mid back, and lower back pain. According to a pain management report dated 9/11/14, the patient complained of constant burning pain in her neck that radiated to the bilateral upper trapezial region. She also described constant tingling and numbness in the fourth and fifth fingers of her right hand. She also complained of mid back pain that does not radiate to her lower extremities. According to the provider, the patient's subjective complaints of numbness and tingling in her right hand and intermittent pain in her right elbow respond to the use of anti-inflammatory medication. Objective findings: tenderness and guarding in cervical paraspinal musculature, restricted range of motion of cervical spine, sensation testing is within normal limits in the C1 through C8 nerve distributions in both upper extremities, full 5/5 muscle strength for all muscle groups in the bilateral upper extremities. X-rays of the cervical spine show: straightening of the cervical lordosis consistent with myospasms, significant neural foraminal narrowing as a result of anterior translation at the C4-5 level and significant disc collapse of the C4-6 and C6-7 segments. Diagnostic impression: anterolisthesis, C4-5, causing cervical stenosis; significant disc collapse, C5-6 and C6-7; cervical radiculopathy, right upper extremity; facet arthropathy C4-5, C5-6, and C6-7; degenerative disc disease, lumbar spine; degenerative disc disease, thoracic spine. Treatment to date: medication management, activity modification, physical therapy. A UR decision dated 9/22/14 denied the request for EMG Bilateral upper extremities. A specific rationale for denial was not provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**EMG 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 10 Elbow Disorders (Revised 2007) Page(s): 238, Chronic Pain Treatment Guidelines Elbow Disorders. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back Chapter - EMG

**Decision rationale:** CA MTUS criteria for EMG/NCV of the upper extremity include documentation of subjective/objective findings consistent with radiculopathy/nerve entrapment that has not responded to conservative treatment. However, in the present case, it is noted that sensation testing and muscle strength of the cervical spine were normal. In addition, X-rays of the cervical spine show significant neural foraminal narrowing as a result of anterior translation at the C4-5 level and significant disc collapse of the C4-6 and C6-7 segments. The presence of radiculopathy appears well established at this point. It is unclear from the discussions in the documentation how an EMG would clarify the picture and provide information valuable in treatment decision-making. Furthermore, there was no documentation that the patient has failed conservative therapy. In fact, the provider states that the patient's subjective complaints of numbness and tingling respond to the use of anti-inflammatory medication. Therefore, the request for EMG bilateral upper extremities was not medically necessary.