

Case Number:	CM14-0032500		
Date Assigned:	06/11/2014	Date of Injury:	05/24/2011
Decision Date:	07/14/2014	UR Denial Date:	01/22/2014
Priority:	Standard	Application Received:	02/10/2014

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, and is licensed to practice in Illinois. 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 47-year-old male with a reported date of injury on 05/24/2011. The injury reportedly occurred when the injured worker was struck in the head and as a result had a loss of consciousness. His diagnoses were noted to include cervical degenerative disc disease, lumbar degenerative disc disease, upper extremity radiculopathy, lower extremity radiculopathy, and possible cervical spinal stenosis. His previous treatments were noted to include physical therapy, surgery, and medications. The progress note dated 12/11/2013 reported the injured worker complained of sharp neck pain that increased with prolonged sitting, standing, walking, positioning, turning, bending, tilting and pushing, pulling, and lifting. The injured worker noted radiating pain to the bilateral shoulders and in addition, he reported stiffness, numbness, tingling, and cracking of the neck. The injured worker also complained of constant sharp pain in his lower back, which increased with prolonged sitting, standing, walking, climbing, ascending and descending on a flight of stairs, bending, turning, twisting, stooping, squatting, kneeling, pushing, pulling, and lifting. The injured worker noted radiating pain through his bilateral hips, legs, and feet accompanied with weakness, numbness, and tingling sensations. The provider's diagnostic impression was status posttraumatic brain injury (including depression, chronic headaches/tinnitus, chronic pain syndrome), L5-S1 discogenic disease with stenosis, stress acne, status post right shoulder arthroscopy with rotator cuff repair in 2011, and status post bilateral knee arthroscopy 2011/2012. The current medications list includes Norco, ibuprofen 400 mg, and alprazolam 1 mg. The provider reported a mild paraspinal muscle spasm in the cervical and lumbar spine. The provider reported 5/5 strength in the bilateral deltoids, biceps muscle, triceps, wrist flexors, and intrinsic hand muscles. The provider also reported hip flexors, quadriceps, tibialis anterior, and gastroc soleus complex also were 5/5. The deep tendon reflexes were equal bilaterally and there was a positive straight leg raise bilaterally as well as a positive Spurling's

bilaterally. The progress report dated 12/30/2013 reported sensory examination to the upper extremities was grossly intact to pinwheel in all dermatomes. The provider reported the bilateral wrist examination was negative for Tinel's and Finkelstein's, as well as median nerve compression and grind test. The bilateral upper extremity motor testing rated 5/5. An x-ray of the cervical spine revealed decreased lordosis and anterior C5-6 narrowing. The request for authorization was not submitted within the medical records. The request is for urgent electromyography and nerve conduction studies for the left upper extremity and urgent electromyography and nerve conduction studies for the right upper extremity to help identify the cause of the injured worker's symptoms.

IMR ISSUES, DECISIONS AND RATIONALES

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

URGENT EMG FOR LEFT UPPER EXTREMITY: Upheld

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

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

Decision rationale: The request for urgent electromyography for left upper extremity is non-certified. The injured worker has complained of radiating pain to bilateral upper extremities. ACOEM Guidelines state physiological evidence may be in the form of definitive neurological findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. ACOEM states unequivocal findings that identify specific nerve compromise on neurological examination are sufficient evidence to warrant imaging studies if symptoms persist. When neurologic examination is less clear, however, further physiological evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography and nerve conduction velocities, including H-reflex tests, may help identify subtle focal neurological dysfunction in patients with neck or arm symptoms, or both, lasting more than 3 to 4 weeks. The documentation submitted for review reports negative Tinel's and Finkelstein's, sensory intact to all dermatomes, and upper extremity motor strength was rated 5/5. Additionally, the upper extremity reflexes were full and equal bilaterally. There is a lack of documentation regarding neurological deficits, which would warrant the need for an electromyography to the left upper extremity. Therefore, the request is non-certified.

URGENT NCS FOR LEFT UPPER EXTREMITY: Upheld

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

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

Decision rationale: The request for urgent nerve conduction study for left upper extremity is non-certified. The injured worker complains of radiating pain from his cervical spine to the bilateral upper extremities. ACOEM Guidelines state physiological evidence may be in the form of definitive neurological findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. ACOEM states that equivocal findings that identify specific nerve compromise on the neurological examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurological examination is less clear, however, further physiological evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography and nerve conduction velocities, including H-reflex tests, may help identify subtle focal neurological dysfunction in patients with neck or arm symptoms, or both, lasting more than 3 to 4 weeks. The physical examination provided reported negative Tinel's and Finkelstein's tests to the bilateral wrists as well as intact sensory to all dermatomes, and motor strength testing to the bilateral upper extremities was 5/5. Additionally, the upper extremity reflexes were full and equal. Therefore, due to the lack of documentation regarding neurological deficits to warrant a nerve conduction study, it is inappropriate at this time. Therefore, the request is non-certified.

URGENT EMG FOR RIGHT UPPER EXTREMITY: Upheld

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

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

Decision rationale: The request for urgent electromyography for right upper extremity is non-certified. The injured worker has complained of radiating pain to bilateral upper extremities. ACOEM Guidelines state physiological evidence may be in the form of definitive neurological findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. ACOEM states unequivocal findings that identify specific nerve compromise on neurological examination are sufficient evidence to warrant imaging studies if symptoms persist. When neurologic examination is less clear, however, further physiological evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography and nerve conduction velocities, including H-reflex tests, may help identify subtle focal neurological dysfunction in patients with neck or arm symptoms, or both, lasting more than 3 to 4 weeks. The documentation submitted for review reports negative Tinel's and Finkelstein's, sensory intact to all dermatomes, and upper extremity motor strength was rated 5/5. There is a lack of documentation regarding neurological deficits, which would warrant the need for an electromyography to the left upper extremity. Additionally, the upper extremity reflexes were full and equal bilaterally. Therefore, the request is non-certified.

URGENT NCS FOR RIGHT UPPER EXTREMITY: Upheld

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

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

Decision rationale: The request for an urgent nerve conduction study for right upper extremity is non-certified. The injured worker complains of radiating pain from his cervical spine to the bilateral upper extremities. ACOEM Guidelines state physiological evidence may be in the form of definitive neurological findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. ACOEM states that equivocal findings that identify specific nerve compromise on the neurological examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurological examination is less clear, however, further physiological evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography and nerve conduction velocities, including H-reflex tests, may help identify subtle focal neurological dysfunction in patients with neck or arm symptoms, or both, lasting more than 3 to 4 weeks. The physical examination provided reported negative Tinel's and Finkelstein's tests to the bilateral wrists as well as intact sensory to all dermatomes, and motor strength testing to the bilateral upper extremities was 5/5. Additionally, the upper extremity reflexes were full and equal bilaterally. Therefore, due to the lack of documentation regarding neurological deficits to warrant a nerve conduction study, it is inappropriate at this time. Therefore, the request is non-certified.