

Case Number:	CM14-0033710		
Date Assigned:	06/20/2014	Date of Injury:	03/27/2013
Decision Date:	07/18/2014	UR Denial Date:	02/20/2014
Priority:	Standard	Application Received:	03/18/2014

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 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 injured worker is a 50 year-old female reporting accumulative trauma from 12/10/09 - 3/27/13 resulting in chronic cervical spine, lumbar spine, and left shoulder pain with myospasm, weakness, and loss of range of motion (reports dated 11/21/13 and 1/2/13). C-spine MRI with flexion/extension (10/26/13) indicates early disc desiccation at the C2-3 to C5-6 levels, mucosal thickening in right maxillary sinus, diffuse disc protrusion effacing the thecal sac at levels C3-4 thru C5-6 with narrowing of each left neural foramen that effaces the left C5 and left C6 exiting roots only. There were no appreciable findings at C6-7 nor at levels C7- thru T1. Multiplanar MRI of the left shoulder (10/26/13) reveals supraspinatus tendinosis with partial tear near its insertion, osteoarthropathy of the acromioclavicular joint and minimal glenohumeral joint effusion. An X-ray (10/18/14) of the left shoulder reveals mild degenerative joint disease of the acromioclavicular joint. A medical summary dated 11/21/14 indicates that the patient has edema of the left shoulder, and positive Codman's Drop arm and Speed's tests and Yergason's sign on the left; motor strength in the deltoid, biceps, wrist extensors, triceps, wrist flexors, finger flexors, and finger abductors on the left is diminished (4/5). There is reported sensory loss in the upper extremities with diminished deep tendon reflexes of the biceps and brachioradialis bilaterally. A request for bilateral upper extremity EMG and NCV studies was originally denied on 2/20/14 on the basis that sufficient detail supporting that request was not apparent from the review of only one medical summary, dated 1/3/14. For this IMR, additional progress reports and summations which date prior to 1/3/14 are provided. These additional reports provide the clinical detail noted above, which indicate that the physiological evidence and imaging studies are unclear as to the source of the right upper extremity sensory loss and diminished reflexes, nor to the diminished strength reported in the distal left extremity. Based upon the guidelines found

in the ACOEM, these additional reports provide the necessary criteria to support the request; the bilateral upper extremity EMG and NCV studies are recommended.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electromyography (EMG) bilateral upper extremity: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment for Workers' Compensation, online edition, Chapter, neck & upper back.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179 ALGORITHM 8-3 186.

Decision rationale: When the physical exam, history and imaging studies are consistent, the ACOEM Guidelines indicate that EMG studies to diagnose root dysfunction are not recommended. In this case, however, it seems that the physiological and imaging findings are unequivocal. Details provided in the exams dated 10/8/13 and 11/21/14 and the C-spine MRI (10/26/13) indicate that the request for bilateral upper extremity EMG/NCV studies is warranted. Specifically, the MRI reveals that the C5 and C6 nerve roots exiting left are effaced by diffuse disk material and facet hypertrophy with narrowing of the left neural foramen (accounting for the diminished left reflexes in the biceps and brachioradialis) whereas the right exiting root is unremarkable. The clinical exam of 11/21/14 indicates that the sensory loss and diminished deep tendon reflexes are demonstrated bi-laterally, with motor strength loss evident in the left extremity only. The correlation of the right physiological exam findings to the imaging of structures clinically relevant to the right extremity is unclear. Further, the physical exam indicates motor weakness to the distal upper left extremity (wrist flexion, finger flexion/abduction, in particular): whereas nerve root dysfunction at nerve roots C7, C8, and T1 correspond to clinically relevant motor weakness to these myotomes, there is no remarkable pathology found in the imaging at these levels. It is not uncommon to have positive MRI findings for disc pathology in the absence of clinically relevant symptomology, but such symptomology in the absence of clear pathology may require additional studies. EMG studies and their inclusive NCV component studies are useful in identifying subtle focal neurologic dysfunction in patients with persisting neck and/or arm symptoms.

Nerve conduction study (NCS): Overturned

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; Algorithm 8-3, p. 186.

Decision rationale: As the nerve conduction velocity study is a component study conducted (for all practical purposes) within the execution of an electromyography study, the rationale

provided for the decision for the bilateral EMG study applies here. When the physical exam, history and imaging studies are consistent, the ACOEM Guidelines indicate that EMG studies to diagnose root dysfunction are not recommended. In this case, however, it seems that the physiological and imaging findings are unequivocal. Details provided in the exams dated 10/8/13 and 11/21/14 and the C-spine MRI (10/26/13) indicate that the request for bilateral upper extremity EMG/NCV studies is warranted. Specifically, the MRI reveals that the C5 and C6 nerve roots exiting left are effaced by diffuse disk material and facet hypertrophy with narrowing of the left neural foramen (accounting for the diminished left reflexes in the biceps and brachioradialis) whereas the right exiting root is unremarkable. The clinical exam of 11/21/14 indicates that the sensory loss and diminished deep tendon reflexes are demonstrated bi-laterally, with motor strength loss evident in the left extremity only. The correlation of the right physiological exam findings to the imaging of structures clinically relevant to the right extremity is unclear. Further, the physical exam indicates motor weakness to the distal upper left extremity (wrist flexion, finger flexion/abduction, in particular): whereas nerve root dysfunction at nerve roots C7, C8, and T1 correspond to clinically relevant motor weakness to these myotomes, there is no remarkable pathology found in the imaging at these levels. It is not uncommon to have positive MRI findings for disc pathology in the absence of clinically relevant symptomology, but such symptomology in the absence of clear pathology may require additional studies. EMG studies and their inclusive NCV component studies are useful in identifying subtle focal neurologic dysfunction in patients with persisting neck and/or arm symptoms.