Case Number:	CM14-0055488		
Date Assigned:	07/09/2014	**Date of Injury:**	08/01/2010
Decision Date:	09/05/2014	**UR Denial Date:**	04/02/2014
Priority:	Standard	**Application Received:**	04/24/2014

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 Internal Medicine and is licensed to practice in Arizona. 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 complainant is a 33-year-old who, on August 1, 2010 was injured when a morbidly obese patient collapsed and fell on her. She immediately had pain to her neck, mid and lower back. She had an L5-S1 fusion in 2013 and uses a 4 wheeled walker for her low back pain. On recent evaluations she has had decreased range of motion of the neck, cervical tenderness, paraspinous and trapezius muscle spasming. Her sensory exam was normal except for a report of increased sensitivity of the ulnar aspect of her right hand. Her motor strength and deep tendon reflex exam were symmetrical and seemingly normal on multiple exams with numerous examiners. The physician ordering the electromyography/nerve conduction velocity (EMG/NCV) stated that he felt electrodiagnostic studies were indicated because she was complaining of radiation of pain down both of her arms. She has had multifocal complaints since her injury and on several Qualified Medical Examiner evaluations has had multi-system complaints on review of systems. She has reported ongoing pain in spite of multiple therapies (including transcutaneous electric nerve stimulation (TENS), physical therapy and Pool therapy, chiropractic treatments and trials of multiple medications, including Prestiq, Valium, flexeril, gabapentin, and anti-inflammatories. The patient had an MRI on April 19, 2013 that was read as normal except for mild spinal canal stenosis, because of a broad-based bulge at C5-6. There have been no new falls or injuries subsequent to her MRI.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG (electromyogram) 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): 169*, 177. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: UpToDate, Clinical features and diagnosis of Cervical Radiculopathy.

Decision rationale: The previous reviewer, who determined that the electromyography/nerve conduction velocity (EMG / NCV) of the upper extremities was not warranted, felt that there was a lack of physical findings suggesting any nerve root injury. This is applicable if there is an acute injury. The Neck and Upper Back Complaints Chapter of the ACOEM Practice Guidelines indicates that if there is cervical nerve root compression with radiculopathy, there should be dermatomal sensory changes, motor weakness and /or reflex changes; if any of these are not present, then no testing is needed for six to eight weeks. When the neurologic examination is less clear however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study, such as an EMG. UpToDate states that neuroimaging and electrodiagnostic testing may be indicated if there are persistent symptoms that do not resolve with 4-6 weeks of conservative therapy. In this case, the patient has already had a cervical MRI, obtained April 2013, which was reported to be normal except for mild spinal stenosis from a broad based C5-6 disk. Her exam and complaints have not seemingly progressed since she had this MRI and there has been no additional trauma. Thus, in light of the normal neurologic exam and the fact that the MRI does not have any disease that requires surgical intervention there is no justification at this time for obtaining cervical EMG testing. The request for an EMG of the bilateral upper extremities is not medically necessary or appropriate.

NCV (nerve conduction velocity) testing 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): 169, 177. Decision based on Non-MTUS Citation UpToDate, Clinical features and diagnosis of Cervical Radiculopathy.

Decision rationale: The previous reviewer, who determined that the electromyography/nerve conduction velocity (EMG / NCV) of the upper extremities was not warranted, felt that there was a lack of physical findings suggesting any nerve root injury. This is applicable if there is an acute injury. The Neck and Upper Back Complaints Chapter of the ACOEM Practice Guidelines indicates that if there is cervical nerve root compression with radiculopathy, there should be dermatomal sensory changes, motor weakness and /or reflex changes; if any of these are not present, then no testing is needed for six to eight weeks. When the neurologic examination is less clear however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study, such as an EMG. UpToDate states that neuroimaging and electrodiagnostic testing may be indicated if there are persistent symptoms that do not resolve

with 4-6 weeks of conservative therapy. In this case, the patient has already had a cervical MRI, obtained April 2013, which was reported to be normal except for mild spinal stenosis from a broad based C5-6 disk. Her exam and complaints have not seemingly progressed since she had this MRI and there has been no additional trauma. Thus, in light of the normal neurologic exam and the fact that the MRI does not have any disease that requires surgical intervention there is no justification at this time for obtaining cervical NCV testing. The request for an NCV of the bilateral upper extremities is not medically necessary or appropriate.