

Case Number:	CM14-0065242		
Date Assigned:	07/11/2014	Date of Injury:	08/31/1998
Decision Date:	09/11/2014	UR Denial Date:	04/17/2014
Priority:	Standard	Application Received:	05/08/2014

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 patient is a 50 year old female employee with date of injury of 8/31/1998. A review of the medical records indicate that the patient is undergoing treatment for brachial Neuritis or Radiculitis NOS. Subjective complaints (2/6/2014) include neck pain radiating to bilateral lower extremities. Objective findings include pain 8/10 with medications (and increasing with activity) on 2/6/14 ; a well-healed surgical scar on cervical spine with vertebral tenderness noted in the cervical spine, myofascial trigger points noted rhomboids and paraspinous muscles bilaterally; tenderness noted in the trapezius muscles bilaterally and paravertebral area L3-S1 levels and bilaterally in the buttock; cervical Range of Motion (ROM) moderately limited due to pain; lumbar ROM moderately to severely limited; Electromyography (EMG) and Nerve Conduction Velocity (NCV) studies were reported on 7/27/12 and 11/4/11. MRI on 4/26/12 revealed: 2mm midline disc protrusion at L5-S1 resulting in mild effacement of the anterior thecal sac with no neural abutment; Scoliotic curvature of the lumbar spine; mild facet arthropathy of the lower lumbar spine; possibility of T2 hyperinnse lesion involving the right kidney (recommend ultrasound). An Electromyography (EMG)/Nerve Conduction Velocity (NCV) of Bilateral Upper Extremities and Bilateral Lower Extremity dated 7/27/12 reported: "mild chronic neuropathic changes in the bilateral C5-6 distribution (no active spontaneous potentials); chronic neuropathic changes in the bilateral L4-5 distribution, with occasional non-sustained active spontaneous potentials in the left anterior tibialis; mild bilateral CTS (median nerve entrapment across the wrist) affecting sensory components." Medications have included Flexeril for musculoskeletal pain, Lidoderm 5% 700mg/patch 1/day for localized pain, MS Contin 30mg #60 1/day for chronic pain, Neurontin 600mg 1-4/day #120 for chronic neuropathic pain, Percocet 10-325mg 4/day #120 for pain. The utilization review dated 4/17/2014 non-certified the request for

Electromyography (EMG) Upper and Lower Extremities Nerve conduction velocity (NCV) Upper and Lower Extremities due to insufficient demonstration of need.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electromyography (EMG) Upper and Lower Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 303,309.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 303, 309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Electrodiagnostic testing (EMG/NCS).

Decision rationale: ACOEM States "Appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful." ODG states "Recommended needle EMG or NCS, depending on indications. Surface EMG is not recommended. Electromyography (EMG) and Nerve Conduction Studies (NCS) are generally accepted, well-established and widely used for localizing the source of the neurological symptoms and establishing the diagnosis of focal nerve entrapments, such as carpal tunnel syndrome or radiculopathy, which may contribute to or coexist with CRPS II (causalgia), when testing is performed by appropriately trained neurologists or physical medicine and rehabilitation physicians (improperly performed testing by other providers often gives inconclusive results). As CRPS II occurs after partial injury to a nerve, the diagnosis of the initial nerve injury can be made by electrodiagnostic studies". ACOEM states "Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks." ODG states in the Low Back Chapter and Neck Chapter, "NCS is not recommended, but EMG is recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. Electrodiagnostic studies should be performed by appropriately trained Physical Medicine and Rehabilitation or Neurology physicians. See also Monofilament testing". The medical documents indicate a prior EMG/NCV dated 7/12/2012. The treating physician does not document what the specific medical reason is for repeat EMG/NCV that is not already established. Additionally, the treating physician does not document what has medically changed to warrant a repeat EMG/NCV. Medical documents also indicate clinically obvious radiculopathy of lower extremities. As such, the request for Nerve conduction velocity (NCV) Upper and Lower Extremities is not medically necessary at this time.

Nerve conduction velocity (NCV) Upper and Lower Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 303,309.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Official Disability

Guidelines (ODG) Pain, Electrodiagnostic testing (EMG/NCS) AND Low Back - Lumbar & Thoracic (Acute & Chronic), EMG, NCV.

Decision rationale: ACOEM States "Appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful." ODG states "Recommended needle EMG or NCS, depending on indications. Surface EMG is not recommended. Electromyography (EMG) and Nerve Conduction Studies (NCS) are generally accepted, well-established and widely used for localizing the source of the neurological symptoms and establishing the diagnosis of focal nerve entrapments, such as carpal tunnel syndrome or radiculopathy, which may contribute to or coexist with CRPS II (causalgia), when testing is performed by appropriately trained neurologists or physical medicine and rehabilitation physicians (improperly performed testing by other providers often gives inconclusive results). As CRPS II occurs after partial injury to a nerve, the diagnosis of the initial nerve injury can be made by electrodiagnostic studies". ACOEM states "Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks." ODG states in the Low Back Chapter and Neck Chapter, "NCS is not recommended, but EMG is recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. Electrodiagnostic studies should be performed by appropriately trained Physical Medicine and Rehabilitation or Neurology physicians. See also Monofilament testing". The medical documents indicate a prior EMG/NCV dated 7/12/2012. The treating physician does not document what the specific medical reason is for repeat EMG/NCV that is not already established. Additionally, the treating physician does not document what has medically changed to warrant a repeat EMG/NCV. Medical documents also indicate clinically obvious radiculopathy of lower extremities. As such, the request for Nerve conduction velocity (NCV) Upper and Lower Extremities is not medically necessary at this time.