

<b>Case Number:</b>	CM14-0068892		
<b>Date Assigned:</b>	07/14/2014	<b>Date of Injury:</b>	08/01/2010
<b>Decision Date:</b>	09/15/2014	<b>UR Denial Date:</b>	05/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/13/2014

### 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 Family 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 33-year-old home caregiver reported low back, neck and L knee after a 320-pound patient collapsed on her during a transfer on 8/1/10. She continues to have chronic pain in her lower and upper back, her neck, both shoulders, both hips and both knees. She also has GI and psychiatric complaints. She has been treated with medications, physical therapy and chiropractic treatment, surgery, TENS, injections, traction, braces and corsets. She is a heavy smoker and uses "medical marijuana". 1/31/12 MRI lumbar spine: mild broad-based posterior disc bulges and degenerative changes, no nerve root compression or narrowing of spinal canal An AME review dated 2/14/14 described the patient as permanent and stationary with lifting, bending and stooping restrictions. The AME did not see justification for electrodiagnostic studies and did not recommend surgery. On 1/7/13: L5-S1 a discectomy, fusion and prosthetic disc placement was performed. The patient was first evaluated by the current primary provider on 1/17/14. Medications at the time included Gabapentin, Pristiq, Diazepam, Zolpidem, Amitiza, Norco, Fexmed, Protonix, occasional Ibuprofen, and other supplements. She was smoking 4 packs per day and using medical marijuana. On 3/15/01 the patient was found unconscious on the floor and transported by ambulance to the hospital, where she was admitted to the ICU. Diagnoses included altered level of consciousness and narcotic dependence. There are multiple progress notes from the primary provider in the record with dates from 1/23/14 through 7/10/14. Nearly all of them document the patient's neurological exam as intact, or do not document a neurological exam. Five of the thirteen notes, including the initial assessment on 1/17, document some focal sensory finding, but in every case it is different: decreased sensation of lateral L thigh (1/17/14), hypersensitivity of the ulnar R hand (4/3/14), decreased sensation of the radial R forearm and anterolateral R knee (4/22/14), decreased sensation of the bottom of the L foot (5/15/14), and hypersensitivity of the radial L hand and forearm (6/12/14). The notes documenting normal

neurological exam or with no documentation of any neurological exam are interspersed among the exams with focal sensory findings. The focal findings are never commented upon as of concern or as meriting further study. Several of the notes document that a request for bilateral upper and lower extremity neurodiagnostic studies, with the explanation that the patient is experiencing radiating pain to all four extremities. The request for bilateral upper extremity studies was first denied in UR on 4/2/14. An appeal was addressed and again denied on 5/13/14 on the basis that the appeal had provided no new information. A request for Independent Medical Review (IMR) was submitted for this decision. Interestingly, there is a report in the chart documenting a normal upper extremity EMV/NCS performed 7/3/14, apparently without authorization.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Electromyography:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines Neck Pain Subsection Under EMG/NCV.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 170,171 182; 259, 272, Chronic Pain Treatment Guidelines Page(s): 6, 10.

**Decision rationale:** The MTUS Guidelines cited above state that a thorough history and physical exam are important to establish and confirm diagnoses and to understand and to observe and understand pain behavior. Diagnostic studies should be ordered in this context and simply for screening purposes. They also state that when a patient is diagnosed with chronic pain and the treatment for the condition is covered in the clinical topics sections but is not addressed in the chronic pain medical treatment guidelines, the clinical topics section applies to that treatment. Per the ACOEM neck and upper back chapter, patient evaluation should include neurological testing with focus on specific sensory, motor and reflex testing that may indicate specific nerve root dysfunction. Sensory testing should include light touch, pressure and pinprick sensations. EMG is recommended to clarify nerve root dysfunction in cases of suspected disk herniation preoperatively or before epidural steroid injection. Per the forearm, wrist and hand chapter, a careful neurological assessment of the patient should include peripheral pulse, motor reflex, and sensory status of the forearm, wrist and hand, and of more proximal structures, as well as examination of the neck and of cervical root function. Routine use of NCV or EMG in diagnostic evaluation or screening of nerve entrapment or screening in patients without symptoms is not recommended. The clinical notes in this case do not document the performance of the kind of careful history, examination and thoughtful assessment prior to ordering testing that is recommended above. The notes either do not include a neurological exam, or include one that is cursory at best. Neurological findings are not consistent from one visit to another, and are never commented on in the notes as grounds for concern or for further testing. None of the neurological findings are consistent with a single nerve root distribution, even if taken alone. Together, they suggest psychosomatic issues rather than any clear neurological diagnosis. The rationale given for ordering EMG/NCV is that the patient has pain radiating to all four

extremities, but there is in fact no description of the pain as originating in neck or back and radiating to extremities. The documentation simply states that the patient has pain in neck, low back and all four extremities. Since her diagnoses include bilateral shoulder, hip and knee problems, the presence of pain in all four extremities is to be expected, and does not establish suspicion for radiculopathy or for nerve entrapment syndromes. Neither upper extremity EMG nor NCV testing is advisable in this setting. Based on the evidence-based citations above, and the clinical findings in this case, upper extremity EMG is not medically necessary based on lack of documentation of a careful history and physical exam with clearly documented rationale for the testing requested. Therefore Electromyography is not medically necessary and appropriate.

**Nerve Conduction Velocity:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines Neck Pain Subsection Under EMG/NCV.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 8 Neck and Upper Back Complaints Page(s): 170,171 182; 259, 272, Chronic Pain Treatment Guidelines Page(s): 6, 10.

**Decision rationale:** The MTUS Guidelines cited above state that a thorough history and physical exam are important to establish and confirm diagnoses and to understand and to observe and understand pain behavior. Diagnostic studies should be ordered in this context and simply for screening purposes. They also state that when a patient is diagnosed with chronic pain and the treatment for the condition is covered in the clinical topics sections but is not addressed in the chronic pain medical treatment guidelines, the clinical topics section applies to that treatment. Per the ACOEM neck and upper back chapter, patient evaluation should include neurological testing with focus on specific sensory, motor and reflex testing that may indicate specific nerve root dysfunction. Sensory testing should include light touch, pressure and pinprick sensations. EMG is recommended to clarify nerve root dysfunction in cases of suspected disk herniation preoperatively or before epidural steroid injection. The clinical notes in this case do not document the performance of the kind of careful history, examination and thoughtful assessment prior to ordering testing that is recommended above. The notes either do not include a neurological exam, or include one that is cursory at best. Neurological findings are not consistent from one visit to another, and are never commented on in the notes as grounds for concern or for further testing. None of the neurological findings are consistent with a single nerve root distribution, even if taken alone. Together, they suggest psychosomatic issues rather than any clear neurological diagnosis. The rationale given for ordering EMG/NCV is that the patient has pain radiating to all four extremities, but there is in fact no description of the pain as originating in neck or back and radiating to extremities. The documentation simply states that the patient has pain in neck, low back and all four extremities. Since her diagnoses include bilateral shoulder, hip and knee problems, the presence of pain in all four extremities is to be expected, and does not establish suspicion for radiculopathy or for nerve entrapment syndromes. Neither upper extremity EMG nor NCV testing is advisable in this setting. Based on the evidence-based citations above, and the clinical findings in this case, upper extremity EMG is not medically necessary based on lack of documentation of a careful history and physical exam with clearly

documented rationale for the testing requested. Therefore Nerve Conduction Velocity is not medically necessary and appropriate.