

<b>Case Number:</b>	CM14-0192862		
<b>Date Assigned:</b>	11/26/2014	<b>Date of Injury:</b>	01/29/2008
<b>Decision Date:</b>	01/20/2015	<b>UR Denial Date:</b>	11/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/18/2014

### 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 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:

The injured worker is a 52-year-old female who sustained an industrial related injury 01/29/08 while she worked as a certified nursing assistant. The injury was reported as occurring while she was in the process of transferring a heavy patient from bed to wheelchair. Per the Qualified Medical Evaluation (QME) done 05/01/14, there was a second injury noted that occurred 07/01/09 while she was working as a certified nursing assistant. She reported slipped and fell, landing on her hands and knees. She had an increase in her low back pain and pain at both wrists, hands, and both knees. She stopped working and was seen in the emergency room. X-rays were taken which revealed a fracture of the left kneecap. Knee surgery was not required, symptoms improved with time and conservative treatment. Following the July 2009 injury she was troubled with neck pain, pain in both wrists and hands with numbness and tingling more to the left, increased low back pain, and pain in her knees. Her right knee pain resolved but she was left with ongoing symptoms on the left side. She seemed to recall she was told she had a "pinched nerve" detected by the cervical MR scan. She noted the electrodiagnostic studies were done only at the neck and upper extremities. She currently complained of constant pain at the neck, flexion and extension of the neck and turning the head will increase the symptoms. She had radiating pain along the spine from the neck to the tailbone. There was numbness and tingling to the right arm and hand involving all fingers. Pushing, pulling, and lifting increases the symptoms. She reported having little tolerance to lifting away from the body and cannot use her right arm overhead effectively. The numbness produced diminished manual dexterity, she drops small objects, such as coins, fasteners, or pills. There is pain to the radial side of both wrists produced and aggravated by gripping, grasping, and torque activities. Per the QME report, there was a cervical MR done 10/22/13 which revealed mild to moderate spinal stenosis at C6-7 due to discogenic disease, disc protrusion at C6-7, and degenerative disc disease at C4-5

and C5-6. The QME objective findings noted there was no abnormality of the neck. The worker complained of tenderness to palpation at the base of the cervical spine and over the trapezius area, more to the right of the vertebral column. Range of motion was limited at the cervical spine. Flexion was normal to 45 degrees, extension was limited to 45 degrees compared to normal average of 60 degrees. Sensory examination of the upper extremities revealed there was numbness to sharp stimulation with a pinwheel in a C6 dermatome pattern in the right upper extremity extending to the radial side of the hand. Circumferential measurements were taken at the point of maximum circumference in the arms and forearms. The right-dominant arm measures 29 cm and the left non-dominant arm measures 27 cm. The forearms measure 21.5 cm right and 22 cm left, wrist measurements were 15 cm bilaterally. Mid-palmar measurements, with the tape on the distal palmar crease, are 16.5 cm left and 17 cm right. Grip strength was tested with the Jamar dynamometer at 40 pounds/40 pounds/38 pounds in the right-dominant hand, and 30 pounds/30 pounds/30 pounds in the left non-dominant hand. She complained of diffuse upper extremity pain and pain at both wrists with gripping. Effort with the dynamometer does not appear to be maximum. Percussion at the right supraclavicular region produces numbness or tingling radiating into the upper extremity (positive Tinel's sign). Tinel's sign was negative at the carpal tunnels and ulnar canals bilaterally. Upon abduction and external rotation of the arms, when she turns her head to the opposite side, she complains of increased pain at the base of the neck on the right, radial pulse remained stable, and there was no increased numbness with Adson's maneuver. Inspection of the right-dominant wrist revealed no abnormalities. She complained of tenderness to palpation at the radial side and at the basilar joint of the thumb, range of motion was normal. Wrist could be flexed and dorsiflexion was possible to 60 degrees. Radial deviation could be completed to 20 degrees and ulnar deviation to 30 degrees with pain on extension and radial deviation. The left non-dominant wrist revealed no abnormalities. She complained of tenderness to palpation at the flexor carpi radialis insertion and at the base of the thumb, range of motion was normal. The left wrist could be flexed and dorsiflexion was possible to 60 degrees. Radial deviation could be completed to 20 degrees and ulnar deviation to 30 degrees with pain on extension and radial deviation. Diagnoses addressing the neck and upper extremities were chronic discogenic neck pain with right C5-6 cervical radiculopathy, multilevel degenerative cervical disc disease with disc protrusion and spinal stenosis C6-7 by MR scan, chronic right wrist pain/sprain, and chronic left wrist pain/sprain. There is a clinical note dated 07/25/14 which noted the normal EMG findings were discussed with the patient. She was encouraged to continue her home exercises and stretching and to take medications as prescribed. There was a document from a physician on behalf of the carrier for a request of a left upper extremity EMG, noting she had chronic cervicalgia, predominant left upper extremity radiculopathic and neuropathic pain with myofascial strain from industrial injury of 01/29/08. There seems to be some complexity in this case and lack of clarification as to which body part(s) were injured on which date since the claimant has multiple industrial claims. In addition, there seemed to be varying physician opinions as to whether or not the patient has cervical radiculopathy. There were other clinic visit reports available for review. The subjective and objective findings were similar with the QME's findings.

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

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

**EMG of the left upper extremity:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG 2014 web "neck, upper back"- Electromyography (EMG)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 28-29, 209-210, 238. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic), Left upper extremity EMG

**Decision rationale:** Guidelines state this test may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. Guidelines also state there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. The request is not reasonable as the patient has not received 1 month conservative care prior to their request. Additionally, patient noted the electrodiagnostic studies were done only at the neck and upper extremities. She currently complained of constant pain at the neck, flexion and extension of the neck and turning the head will increase the symptoms. She had radiating pain. There was numbness and tingling to the right arm and hand involving all fingers. The rationale for request is not clear as no complaints of left upper extremity documented. Also, it is unclear why repeat studies are needed. Therefore, this request is not medically necessary.