

<b>Case Number:</b>	CM14-0198107		
<b>Date Assigned:</b>	12/08/2014	<b>Date of Injury:</b>	08/16/2012
<b>Decision Date:</b>	01/20/2015	<b>UR Denial Date:</b>	10/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/25/2014

### 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 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 (IW) is a 61-year-old woman with a date of injury of August 16, 2012. The mechanism of injury is documented as a cumulative trauma while working as a special education teacher. She had complains of low back pain. She was referred to a pain management specialist who prescribed acupuncture, aquatic therapy, and chiropractic treatment. She had an MRI of the lumbar spine, and an epidural injection in 2013, which provided temporary relief. She was then referred to a neurosurgeon who recommended cervical and lumbar surgery. Current diagnoses are chronic cervical strain; cervical spondylosis at C4-T1; chronic lumbar strain; lumbar spondylosis and degenerative disc disease at L5-S1; Fibromyalgia; anxiety disorder; insomnia; moderate right cubital tunnel syndrome; mild bilateral carpal tunnel syndrome (CTS). MRI of the cervical spine demonstrates severe bilateral neural foraminal stenosis at C3-C4; moderate to severe left and severe right neural foraminal stenosis at C4-C5; severe bilateral neural foraminal stenosis and moderate canal stenosis at C5-C6; and moderate left neural foraminal stenosis and mild to moderate central stenosis at C7-T1. Pursuant to the Secondary Treating Physician's Progress Report (PR-2) and Request for Authorization dated October 15, 2014, the IW was last evaluated on September 3, 2014, at which time authorization was requested for EMG study of her bilateral lower extremities, as well as consultation to a hand specialist. The IW returns reporting no significant changes in her symptoms. She continues to have constant neck pain that radiates to her bilateral arms associated with numbness and tingling in her bilateral fingers. She has weakness in her wrist. Neurologic exam reveals motor and sensory function of the upper and lower extremities is intact. There is decreased light touch sensation in the left posterior thigh, calf, and foot. In the upper extremities, there is decreased light touch sensation in the left radial arm, radial forearm, hand and left thumb. Gait is normal. Lumbar spine range of motion is moderately decreased with pain at the limits of her range. There is positive Tinel's sign over the

wrists bilaterally. The IW is taking Mobic and Tramadol for pain. The IW underwent electric diagnostic studies (EDS) on August 26, 2014, which revealed mild CTS bilaterally, moderate right cubital tunnel syndrome and no evidence of cervical radiculopathy. The current request is for EMG/NCV of the bilateral upper extremities, and bilateral lower extremities, and consultation with a hand specialist.

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

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

#### **EMG/NCV of the bilateral upper extremities: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181-183.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Neck Section, EMG/NCV

**Decision rationale:** Pursuant to the Official Disability Guidelines, EMG/NCV of the bilateral upper extremities is not medically necessary. Nerve conduction studies are not recommended to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but recommended if the EMG is not clearly radiculopathy or clearly negative or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely based on the clinical exam. In this case, the injured worker is 61 years old with a date of injury August 6, 2012. The injured worker's diagnoses are multilevel cervical spondylosis with stenosis and nerve root narrowing; multilevel lumbar spondylosis with left L5 - S1 severe recess stenosis; fibromyalgia; and associated mood disorder. The medical record not contain subjective or objective evidence of cervical radiculopathy. Additionally electrodiagnostic studies of the upper extremities were performed in August 2014. The impression was mild carpal tunnel syndrome bilaterally, right moderate cubital tunnel syndrome and no evidence of cervical radiculopathy. Consequently, the EMG/NCV of the bilateral upper extremities is not medically necessary.

#### **EMG/NCV to bilateral lower extremities:**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Low Back, EMG/NCV

**Decision rationale:** Pursuant to the Official Disability Guidelines, EMG/NCV of the bilateral lower extremities is not medically necessary. The guidelines do not recommend nerve conduction velocity studies. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. EMGs are

recommended and may be useful to obtain unequivocal evidence of radiculopathy, after one month conservative therapy, but are not necessary if radiculopathy is already clinically obvious. In this case, the injured worker is 61 years old the date of injury August 6, 2012. The injured worker's diagnoses are multilevel cervical spondylosis with stenosis and nerve root narrowing; multilevel lumbar spondylosis with left L5 - S1 severe recess stenosis; fibromyalgia; and associated mood disorder. The documentation does not contain any clinical evidence, symptoms or signs of radiculopathy or nerve entrapment involving the lower extremities. There is no clinical indication or clinical rationale in the medical record to perform an EMG/NCV of the lower extremity. Consequently, the EMG/NCV of the bilateral lower extremities is not medically necessary.