

Case Number:	CM14-0200129		
Date Assigned:	12/10/2014	Date of Injury:	08/28/2009
Decision Date:	01/26/2015	UR Denial Date:	11/05/2014
Priority:	Standard	Application Received:	12/01/2014

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 sustained a work related injury on August 28, 2009, from a motor vehicle accident, with secondary strain/injury to right shoulder and right foot/heel. The injured worker was noted to have undergone a right calcaneal spur resection on January 7, 2013, debridement of the right calcaneal tendon with tendon repair on March 27, 2014, debridement of the right calcaneal spur October 17, 2014, a left shoulder scope, arthroscopic subacromial decompression, resection of the distal clavicle, and biceps tenodesis open on September 1, 2010, and a right shoulder scope with debridement and decompression on June 29, 2014. The surgical reports were not included in the documentation provided. The injured worker's previous conservative treatments were noted to have included chiropractic care, cortisone injections, oral medications, and physical therapy. The Primary Treating Physician's report dated November 1, 2014, noted the injured worker with pain and numbness in the right neck and posterior shoulder to the right index finger. The Physician noted it was unclear if this was an aggravation from the recent surgery/anesthesia. Physical examination was noted to show the right shoulder/neck with no swelling, ecchymosis, atrophy, crepitation, or tenderness over the right upper trapezius, with normal range of motion. The diagnoses were noted to be a calcaneal spur of right foot, cervical (neck) region somatic dysfunction, right shoulder tendinitis, and numbness of the finger. The Physician noted the plan was to request authorization for a repeat electromyography (EMG) and nerve conduction study (NCS) of the cervical spine to evaluate persistent neck pain and numbness at C6. On November 5, 2014, Utilization Review evaluated the request for an EMG of the cervical spine C6, and a NCS of the cervical spine C6, citing the MTUS American College of Occupational and Environmental Medicine (ACOEM) Guidelines, Neck and Upper Back Complaints, and the Official Disability Guidelines (ODG), Neck and Upper Back, updated August 4, 2014. The UR Physician noted the record review's neurological examination revealed

the deep tendon reflexes were 1-2+ and symmetric in the upper and lower extremities, and pathologic reflexes were grossly normal, as were the injured worker's sensation and motor function. The UR Physician noted that as there were no abnormal neurologic findings, including sensorimotor changes noted, the necessity of the EMG of the cervical spine C6, and a NCS of the cervical spine C6 was not established, and based on the clinical information submitted and the evidence based guidelines, the request was non-certified. The decision was subsequently appealed to Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG cervical spine C6: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back (updated 08/04/14)

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

Decision rationale: Pursuant to the Official Disability Guidelines, EMG cervical spine C6 is not medically necessary. Nerve conduction velocity 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. There is minimal justification for performing nerve conduction studies when the patient is already presumed to have symptoms of radiculopathy. While cervical electrodiagnostic studies are not necessary to demonstrate a cervical radiculopathy, they have been suggested to be from a brachial plexus abnormality or some problem other than cervical radiculopathy. In this case, a review of the medical record indicates the working diagnoses are Achilles tendinitis of the right lower extremity; calcaneal spur of the right foot; heel pain right; and shoulder bursitis; cervical (neck) regional somatic dysfunction. The progress note dated November 1, 2014 documents and EMG nerve conduction study was performed at [REDACTED] on or about March 2013. The injured worker reportedly had a plexus injury. A second EMG nerve conduction velocity study was done on September 16, 2013 that showed a C7 injury. The injured worker would like a repeat EMG nerve conduction velocity study to determine the etiology of his pain. The injured worker had a disc bulge at C7 on MRI done at [REDACTED]. There were no subjective complaints in the upper extremities noted on the progress note. Physical examination did not show any abnormalities referencing radiculopathy of the upper extremities. There was no weakness or sensory disturbance noted in an entry on the progress note dated April 28, 2013. MRI scan right brachial plexus was done at [REDACTED]. The impression states suspect right-sided brachial neuritis most greatly affecting her right C7 middle trunk level. No infiltrate, kinking from external compression seen, prominent lymph nodes with greater than expected ill-defined thymic tissue for age. The treatment plan in the progress note states request authorization for repeat (third time) EMG/nerve conduction velocity studies. The documentation does not show any subjective or objective complaints on physical examination. The prior two EMG/NCVs should be reviewed.

There is no clinical indication to repeat an EMG/NCV for the third time absent subjective and objective clinical findings on examination. There were no findings in the November 1, 2014 progress note. Consequently, absent the appropriate clinical indications and rationale, EMG cervical spine C6 is not medically necessary.

NCS cervical spine C6: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back (updated 08/04/14)

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, NCV

Decision rationale: Pursuant to the Official Disability Guidelines, NCV cervical spine C6 is not medically necessary. Nerve conduction velocity 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. There is minimal justification for performing nerve conduction studies when the patient is already presumed to have symptoms of radiculopathy. While cervical electrodiagnostic studies are not necessary to demonstrate a cervical radiculopathy, they have been suggested to be from a brachial plexus abnormality or some problem other than cervical radiculopathy. In this case, a review of the medical record indicates the working diagnoses are Achilles tendinitis of the right lower extremity; calcaneal spur of the right foot; heel pain right; and shoulder bursitis; cervical (neck) regional somatic dysfunction. The progress note dated November 1, 2014 documents and EMG nerve conduction study was performed at [REDACTED] on or about March 2013. The injured worker reportedly had a plexus injury. A second EMG nerve conduction velocity study was done on September 16, 2013 that showed a C7 injury. The injured worker would like a repeat EMG nerve conduction velocity study to determine the etiology of his pain. The injured worker had a disc bulge at C7 on MRI done at [REDACTED]. There were no subjective complaints in the upper extremities noted on the progress note. Physical examination did not show any abnormalities referencing radiculopathy of the upper extremities. There was no weakness or sensory disturbance noted in an entry on the progress note dated April 28, 2013. MRI scan right brachial plexus was done at [REDACTED]. The impression states suspect right-sided brachial neuritis most greatly affecting her right C7 middle trunk level. No infiltrate, kinking from external compression seen, prominent lymph nodes with greater than expected ill-defined thymic tissue for age. The treatment plan in the progress note states request authorization for repeat (third time) EMG/nerve conduction velocity studies. The documentation does not show any subjective or objective complaints on physical examination. The prior two EMG/NCVs should be reviewed. There is no clinical indication to repeat an EMG/NCV for the third time absent subjective and objective clinical findings on examination. There were no findings in the November 1, 2014 progress note. Consequently, absent the appropriate clinical indications and rationale, NCV cervical spine C6 is not medically necessary.

