

<b>Case Number:</b>	CM14-0203849		
<b>Date Assigned:</b>	12/15/2014	<b>Date of Injury:</b>	03/04/2014
<b>Decision Date:</b>	02/25/2015	<b>UR Denial Date:</b>	11/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/05/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: Pennsylvania, Ohio, California  
 Certification(s)/Specialty: Physical Medicine & Rehabn

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

According to the records made available for review, the injured worker is a 42 year-old male with a date of injury of 03/04/2014. The results of the injury include cervical spine, thoracic spine, and lumbosacral spine pain. Diagnoses have included cervical strain/sprain; cervical spondylosis; thoracic strain/sprain/ lumbosacral strain/sprain, lumbosacral spine degenerative disc disease, and right ankle strain/sprain. Treatments have included medications. Medications have included Ultram, Protonix, Cyclobenzaprine, and Naproxen. A progress noted from the treating physician, dated 10/21/2014, documents an orthopedic re-evaluation of the injured worker. The injured worker reports constant moderately severe pain in the cervical spine, which radiates into the intrascapular area, and at times, is associated with severe headaches; mild generalized weakness of both upper extremities; moderately severe to severe pain of the lumbosacral spine, with radiation into the posterolateral aspect of the right lower extremity into the foot; weakness of the right lower extremity with loss of sensation; pain of the lateral aspect of the right foot and ankle worsens upon ambulation; and all of the above-mentioned areas of pain worsen with activities involving turning, twisting, and bending. Objective findings include tenderness of the spinous process in the mid to lower portion of the cervical spine; moderate bilateral paraspinal muscle guarding with tenderness; decreased range of motion; no localizing sensory or motor deficit of either upper extremity; paraspinal and infrascapular muscle guarding with tenderness of the thoracic spine; and spinous process tenderness from L3 to the sacrum level, with guarding of movement, and decreased range of motion. Plan of treatment includes the recommendation for EMG/NCV studies; continuation of medications including Protonix,

Ultram, and Cyclobenzaprine; and follow-up evaluation. Request is being made for EMG/NCV to the right upper extremity. On 11/04/2014, Utilization Review non-certified a prescription for EMG/NCV to the right upper extremity. Utilization Review non-certified a prescription for EMG/NCV to the right upper extremity based on the criteria for this testing not being met, according to evidence-based guidelines. The Utilization Review cited the CA MTUS (2009) ACOEM: Occupational Medical Practice Guidelines, Second Edition (2004): Chapter 8 and Chapter 12; and the Official Disability Guidelines: Treatment Index, 12th Edition (web) (2014): Neck and Upper Back: NCS; Low Back: NCS. Application for independent medical review was made on 12/04/2014.

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

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

**EMG/NCV to the right upper extremity:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

**Decision rationale:** ACOEM guidelines recommend electrodiagnostic studies if a patient has soft or unclear neurological symptoms of unknown etiology. A prior physician review noted that this patient does not have definitive findings to support the presence of a radiculopathy, and, therefore, an electrodiagnostic study would not be indicated. The treatment guidelines, however, indicate the opposite. Specifically, the treatment guidelines suggest that if a radiculopathy is clinically obvious then there is no indication for electrodiagnostic studies, and imaging should be used to confirm the diagnosis. In the current situation, this patient has radiating neurological symptoms, although the specific distribution is not certain. The differential diagnosis in this case could include a focal peripheral neuropathy versus a generalized peripheral neuropathy versus polyradiculopathy. The treatment guidelines do support an indication for electrodiagnostic studies in this situation. This request is medically necessary.