

Case Number:	CM14-0021555		
Date Assigned:	05/07/2014	Date of Injury:	08/01/2013
Decision Date:	01/16/2015	UR Denial Date:	01/27/2014
Priority:	Standard	Application Received:	02/20/2014

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 North Carolina. 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 patient has a reported date of injury of 08/01/2012-08/01/2013. The patient has the diagnoses of cervical sprain/strain, lumbar sprain/strain, thoracic sprain/strain and myofascial pain syndrome. Per the progress notes provided for review from the primary treating physician dated 01/10/2014, the patient had complaints of neck pain, constant back pain, low back spasm, daily headaches, numbness in the left leg and ear pain. Prior treatment modalities have included chiropractic care. The physical exam noted restricted cervical range of motion, positive compression test and tender paraspinal muscles. The lumbar spine showed decreased flexion with painful range of motion, positive bilateral straight leg raise test, positive Milgram's test and tender paraspinal muscles. Treatment plan recommendations included continued chiropractic care, psychology consult for anxiety and panic attacks and neurodiagnostic testing of the bilateral upper and lower extremities. Neurodiagnostic studies performed on 11/21/2013 of the lower extremities (NCV) were reported normal.

IMR ISSUES, DECISIONS AND RATIONALES

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

ELECTROMYOGRAPHY (EMG) BILATERAL UPPER EXTREMITIES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines neck and upper back complaints Page(s): 178.

Decision rationale: The ACOEM chapter on neck and upper back complaints and EMG/NCV states: Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. The assessment may include sensory-evoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected. If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps, including the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, compute tomography [CT] for bony structures). Additional studies may be considered to further define problem areas. The recent evidence indicates cervical disk annular tears may be missed on MRIs. The clinical significance of such a finding is unclear, as it may not correlate temporally or anatomically with symptoms. The provided progress notes show no neurologic deficits in the upper extremities. In the absence of any recorded abnormalities, the need for bilateral upper extremity EMG/NCV has not been established or criteria met as outline above per the ACOEM. Therefore the request is not medically necessary.

NERVE CONDUCTION VELOCITY TEST BILATERAL UPPER EXTREMITIES:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines neck and upper back complaints Page(s): 178.

Decision rationale: The ACOEM chapter on neck and upper back complaints and EMG/NCV states: Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. The assessment may include sensory-evoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected. If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps, including the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, compute tomography

[CT] for bony structures). Additional studies may be considered to further define problem areas. The recent evidence indicates cervical disk annular tears may be missed on MRIs. The clinical significance of such a finding is unclear, as it may not correlate temporally or anatomically with symptoms. The provided progress notes show no neurologic deficits in the upper extremities. In the absence of any recorded abnormalities, the need for bilateral upper extremity EMG/NCV has not been established or criteria met as outline above per the ACOEM. Therefore the request is not medically necessary.