Case Number:	CM15-0105951		
Date Assigned:	06/10/2015	**Date of Injury:**	01/14/2010
Decision Date:	07/13/2015	**UR Denial Date:**	05/21/2015
Priority:	Standard	**Application Received:**	06/02/2015

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: North Carolina
Certification(s)/Specialty: Family Practice

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 40 year old female, who sustained an industrial injury on 01/14/2010. She has reported injury to the neck, bilateral shoulders, left elbow, left knee, and low back. The diagnoses have included chronic cervical strain, rule out disc herniation; chronic lumbar strain, rule out disc herniation; left cubital tunnel syndrome; bilateral carpal tunnel syndrome; bilateral shoulder impingement syndrome; and left knee strain, rule out meniscal tear. Treatment to date has included medications, diagnostics, injections, and physical therapy. Medications have included Kera-Tek gel. A progress report from the treating physician, dated 04/15/2015, documented an evaluation with the injured worker. Currently, the injured worker complains of constant neck pain with radiation into the shoulders, arms, hands, and fingers; numbness and tingling in the hands and fingers, as well as weakness of the upper extremities and hands; pain is rated at 6-8 on a scale of 1 to 10; headaches; constant pain in both shoulders; instability of both shoulders; clicking, popping, and grinding in the left shoulder; swelling, numbness, tingling, and burning sensations; pain is rated at 8 on a scale of 1 to 10; constant pain in both wrists/hands; the pain is associated with numbness and tingling, as well as swelling of the hands and fingers; loss of grip strength and loss of sensation; pain is rated at 7 on a scale of 1 to 10; constant lower back pain that radiates into the legs down into the feet; the pain is rated at 10 on a scale of 1 to 10; constant left knee pain; giving way of the knee; pain is rated at 6-8 on a scale of 1 to 10; and she is experiencing sleep difficulties. Objective findings included tenderness to palpation of the levator scapulae muscles and trapezius muscles; cervical compression test was positive; Spurling's test was positive on the left; tenderness of the lumbar paraspinal muscles and lumbar

spine; straight leg raise test was positive on the left; Kemp's test was positive bilaterally; Neer's and Hawkins impingement tests were positive; Tinel's ulnar nerve test was positive on the left; Tinel's median nerve test was positive bilaterally; Phalen's test was positive on the left; and there was tenderness to palpation of the left knee medial joint line. The treatment plan has included the request for EMG (Electromyography) of the bilateral upper and lower extremities; and NCV (Nerve Conduction Velocity) of the bilateral upper and lower extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG of the bilateral upper & lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 10 Elbow Disorders (Revised 2007), Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints Page(s): 178, 33, 261, 303. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck & Upper Back (Acute & Chronic): Electromyography (2015 Official Disability Guidelines, Low Back-Lumbar & Thoracic (Acute and Chronic): Electromyography (2015).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173-174.

Decision rationale: The ACOEM chapter on neck and upper back complaints and special diagnostic studies states: Criteria for ordering imaging studies are: "Emergence of a red flag; Physiologic evidence of tissue insult or neurologic dysfunction; Failure to progress in a strengthening program intended to avoid surgery; Clarification of the anatomy prior to an invasive procedure." 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, computer 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 documentation does not show any signs of emergence of red flags or subtle physiologic evidence of tissue insult or neurologic dysfunction. There is no mention of planned invasive procedures. There are no subtle neurologic findings listed on the physical exam. For these reasons criteria for special diagnostic testing has not been met per the ACOEM. Therefore, the request is not medically necessary.

NCV of the bilateral upper & lower extremities: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck & Upper Back (Acute & Chronic): Nerve Conduction Studies (2015).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173-174.

Decision rationale: The ACOEM chapter on neck and upper back complaints and special diagnostic studies states: Criteria for ordering imaging studies are "Emergence of a red flag; Physiologic evidence of tissue insult or neurologic dysfunction; Failure to progress in a strengthening program intended to avoid surgery; Clarification of the anatomy prior to an invasive procedure." 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, computer 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 documentation does not show any signs of emergence of red flags or subtle physiologic evidence of tissue insult or neurologic dysfunction. There is no mention of planned invasive procedures. There are no subtle neurologic findings listed on the physical exam. For these reasons criteria for special diagnostic testing has not been met per the ACOEM. Therefore, the request is not medically necessary.