

Case Number:	CM15-0011930		
Date Assigned:	03/11/2015	Date of Injury:	06/22/2012
Decision Date:	04/09/2015	UR Denial Date:	01/09/2015
Priority:	Standard	Application Received:	01/20/2015

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: California, Indiana, New York
Certification(s)/Specialty: Internal Medicine

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 45-year-old female who sustained an industrial injury on June 22, 2012. She has reported neck pain, bilateral elbow pain, bilateral wrist pain, low back pain, bilateral knee pain, and bilateral ankle and foot pain and has been diagnosed with cervical spine pain, cervical spine radiculopathy, bilateral elbow pain, rule out bilateral elbow lateral epicondylitis, rule out bilateral carpal tunnel syndrome, low back pain, lumbar disc displacement (herniated nucleus pulposus), lumbar radiculopathy, bilateral knee pain internal derangement, bilateral ankle and foot pain, rule out bilateral plantar fasciitis. Treatment has included medications, physiotherapy, and shockwave therapy. Currently the injured worker has tenderness to palpation in the occiputs, trapezius, and at the C7 spinous process, there was mild tenderness to palpation at the lateral epicondyles. There was tenderness to palpation at the paralumbar muscles and the quadratus lumborum as well as over the lumbosacral junction. The treatment plan included medications. On January 9, 2015, Utilization Review non-certified EMG/NCS of bilateral upper extremity citing the Official Disability Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCS of the bilateral upper 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 (ODG), Forearm, Wrist and Hand Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178. 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. The ACOEM states (chapter 8 page 178) unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging 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. 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-neuropathies if other diagnoses may be likely based on physical examination. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy. While cervical electrodiagnostic studies are not necessary to demonstrate his cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality, diabetic property or some problem other than cervical radiculopathy. In this case, the injured workers working diagnoses are cervical spine sprain; bilateral elbow sprain/strain; bilateral wrist sprain/strain; bilateral knee sprain and internal derangement; and bilateral plantar fasciitis and right metatarsalgia. An electrodiagnostic study was performed September 25, 2012. A two line result is present in utilization review but a formal full-length copy is not in the medical record results showed a left median nerve first digital (thumb) lateral branch +1 mild left ulnar palmar branch +1 mild. The full report and impression is not in the medical record. Prior to ordering a new EMG/NCV of the bilateral upper extremities, the treating physician should obtain a copy of the full length report of the EMG/NCV performed September 25, 2012. There is no specific nerve compromise on neurologic examination except numbness and tingling of the hands bilaterally and aching in the neck that radiates to the trapezius. Consequently, absent clinical documentation of the prior EMG/NCV performed in 2012 with nonspecific subjective symptoms, EMG/NCV of the bilateral upper extremities is not medically necessary.