

Case Number:	CM15-0161136		
Date Assigned:	08/28/2015	Date of Injury:	05/15/2014
Decision Date:	09/30/2015	UR Denial Date:	07/24/2015
Priority:	Standard	Application Received:	08/18/2015

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 32 year old female who sustained a repetitive industrial injury on 05-15-2014. The injured worker was diagnosed with cervical sprain and lumbar back sprain. No surgical interventions were documented. Treatment to date has included diagnostic testing with recent Electromyography (EMG) and Nerve Conduction Velocity (NCV) on March 10, 2015 reported as normal, extracorporeal shockwave therapy to the bilateral shoulders and thoracic spine, conservative measures and medications. According to the primary treating physician's progress report on July 23, 2015, the injured worker continues to experience neck, left shoulder and low back pain. Examination of the cervical spine demonstrated normal lordosis with mild tenderness to palpation in the low cervical region. There was full range of motion with negative Spurling's sign. There was mildly positive Tinel's at the left wrist and absent in the right wrist and both elbows. Motor strength and deep tendon reflexes were intact with diminished sensation noted in the left C5 dermatomes otherwise intact. The lumbar spine examination demonstrated normal lordosis, non-antalgic gait and heel and toe walk without difficulty. Tenderness to palpation in the lower lumbar area with full range of motion was documented. Straight leg raise and Faber were negative bilaterally. Motor strength, deep tendon reflexes and sensation were intact throughout the lower extremities. There was full range of motion of both shoulders with pain from her neck to the left shoulder area. Current medication was listed as Tramadol. Treatment plan consists of cervical, lumbar and left shoulder magnetic resonance imaging (MRI) and the current request for Nerve Conduction Velocity (NCV) and Electromyography (EMG) of the upper extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

NCV/EMG upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

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 ACOEM and Official Disability Guidelines, EMG/NCV of the upper extremities is not medically necessary. The ACOEM states (chapter 8 page 178) unequivocal findings that identifies 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 worker's relevant working diagnoses are cervical disc protrusion, myositis, pain, stenosis and disc bulge; thoracic disc herniation/protrusion; thoracic muscle spasm; thoracic myofascitis; thoracic stenosis; lumbar disc protrusion, pain, stenosis. The date of injury is May 15, 2014. Request for authorization is dated July 16, 2014. Utilization review references a July 16, 2014 progress note. A single progress note from the treating provider dated March 5, 2015 shows the injured worker has subjective complaints referable to the head, cervical, thoracic and lumbar spine, right and left shoulders. There were no subjective radicular complaints. Objectively, the lumbar spine was tender to palpation. There was no neurologic evaluation medical record. Based on the clinical information in the medical record, peer-reviewed evidence-based guidelines and no documentation showing subjective symptoms of radiculopathy, no objective evidence of radiculopathy on neurologic evaluation and no documentation of a neurologic evaluation, EMG/NCV of the upper extremities is not medically necessary.