

Case Number:	CM15-0165488		
Date Assigned:	09/03/2015	Date of Injury:	03/06/2013
Decision Date:	10/06/2015	UR Denial Date:	07/25/2015
Priority:	Standard	Application Received:	08/24/2015

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:

This 52 year old sustained an industrial injury to the knee, shoulder, neck, elbow and wrist on 3-6-13. Electromyography and nerve conduction velocity test bilateral upper extremity (3-27-14) showed slight bilateral carpal tunnel syndrome and slight to moderate bilateral cubital tunnel syndrome. In a PR-2 dated 7-2-15, the injured worker complained of ongoing left knee discomfort and pain, increased intensity of numbness and tingling of the left upper extremity, bilateral hip pain, bilateral shoulder pain, bilateral wrist pain with numbness and tingling, bilateral elbow and forearm pain, low back pain, neck pain and upper back pain. Physical exam was remarkable for lumbar spine with tenderness to palpation and muscle spasms and decreased range of motion, thoracic spine with mild tenderness to palpation and muscle spasm, moderate tenderness to palpation with slightly positive impingement bilaterally and decreased range of motion, moderate left hip tenderness with decreased range of motion, cervical spine with tenderness to palpation to the paraspinal musculature with spasms, decreased range of motion, positive left Spurling's sign, tenderness to palpation to the bilateral elbows with positive Tinel's test, bilateral wrists with slight tenderness to palpation, full range of motion, negative Tinel's sign bilaterally and positive Phalen's sign bilaterally. Current diagnoses included bilateral hip strain, lumbar spine radiculopathy, cervical spine with left sided radiculitis and radiculopathy, bilateral wrist tendinitis with bilateral carpal tunnel syndrome, bilateral elbow tendinitis with bilateral cubital tunnel syndrome, bilateral shoulder impingement and strain, thoracic spine strain, left knee pain and left thigh pain. The treatment plan included an orthopedic consultation for bilateral hip pain, magnetic resonance imaging cervical spine, neurosurgery consultation for

left cervical spine radiculopathy and left lumbar radiculopathy, bilateral upper extremity electromyography and nerve conduction velocity test due to persistent symptoms as well as increasing left upper extremity numbness and tingling, left knee brace and continuing medications (Norco, Flexeril, Naproxen Sodium, Omeprazole and Mentherm topical cream).

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCS BUE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

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 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 as they apply to the issue are cervical strain with left sided radiculitis and radiculopathy: bilateral shoulder impingement and strain, left greater than right. The date of injury is March 6, 2013. Request for authorization is July 16, 2015. According to a July 2, 2015 progress note, the injured worker has multiple complaints including neck pain and back pain, left knee pain, bilateral hip, shoulder, wrist, elbow and forearm pain. Objectively, there is no cervical or upper extremity neurologic evaluation. There are no unequivocal objective findings that identify specific nerve compromise. There was no hard copy of the cervical MRI scan done previously. The medical record contains a prior EMG/nerve conduction velocity study dated March 27, 2014. There was no cervical radiculopathy, but a mild carpal tunnel syndrome was noted. There are no compelling clinical facts indicating a repeat EMG/NCV is clinically warranted. The documentation states the injured worker has persistent symptoms with numbness and tingling, although there is no significant change in symptoms or objective clinical findings. Based on clinical information in the medical record, peer-reviewed evidence-based guidelines, prior EMG/NCV that showed a mild carpal

tunnel syndrome, but no cervical radiculopathy and no unequivocal neurologic findings on neurologic examination, EMG/NCV of the bilateral upper extremities is not medically necessary.