

<b>Case Number:</b>	CM15-0180386		
<b>Date Assigned:</b>	09/22/2015	<b>Date of Injury:</b>	08/20/2012
<b>Decision Date:</b>	11/02/2015	<b>UR Denial Date:</b>	09/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/14/2015

### 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: Texas, California

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:

This 32 year old female sustained an industrial injury on 8-20-12. Documentation indicated that the injured worker was receiving treatment for lumbar disc protrusion, lumbar spondylosis, cervical spine herniated nucleus pulposus and lumbar spine trigger points. Previous treatment included lumbar decompression, physical therapy, myofascial release, trigger point injections, activity modification, ice and medications. Magnetic resonance imaging cervical spine (5-5-15) showed degenerative disc disease with multilevel disc bulge and mild central canal and foraminal stenosis. In a PR-2 dated 6-18-15, the injured worker complained of cervical spine pain with upper extremity symptoms, rated 6 out of 10. Physical exam was remarkable for tenderness to palpation to the cervical spine with diminished sensation at bilateral C6 and C7 distributions with range of motion: flexion 50 degrees, extension 40 degrees, bilateral rotation and lateral tilt 35 degrees. In a PR-2 dated 9-3-15, the injured worker complained of cervical spine pain with upper extremity symptoms. Physical exam was unchanged. The treatment plan included magnetic resonance imaging cervical spine, electromyography and nerve conduction velocity test bilateral upper extremity, continuing home exercise and continuing medications. On 9-4-15, Utilization Review noncertified a request for bilateral upper extremity electromyography and nerve conduction velocity test. The medication list include Cyclobenzaprine, Tramadol and Naproxen Sodium.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**EMG/NCV bilateral upper extremities: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain.

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies.

**Decision rationale:** Per ACOEM chapter 12 guidelines, "Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks." Per the ACOEM guidelines cited below, "For most patients presenting with true neck or upper back problems, special studies are not needed unless a three- or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out." "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 patient has had diagnosis of cervical spine herniated nucleus pulposus. The patient had received an unspecified number of PT visits for this injury. Magnetic resonance imaging cervical spine (5-5-15) showed degenerative disc disease with multilevel disc bulge and mild central canal and foraminal stenosis. In a PR-2 dated 6-18-15, and on 9/3/15 the injured worker complained of cervical spine pain with upper extremity symptoms, rated 6 out of 10. Physical exam was remarkable for tenderness to palpation to the cervical spine with diminished sensation at bilateral C6 and C7 distributions with range of motion: flexion 50 degrees, extension 40 degrees, bilateral rotation and lateral tilt 35 degrees. The patient could have peripheral neuropathy or cervical radiculopathy. It is necessary to do electro-diagnostic studies to find out the exact cause of the symptoms in the upper extremities. Electrodiagnostic studies would help to clarify the exact cause of the neurological symptoms and also would help to identify the level at which nerve root impingement may be occurring. This information would guide further management. The request for EMG/NCV bilateral upper extremities is medically appropriate and necessary for this patient at this time.