

<b>Case Number:</b>	CM15-0181037		
<b>Date Assigned:</b>	09/22/2015	<b>Date of Injury:</b>	02/24/2015
<b>Decision Date:</b>	10/27/2015	<b>UR Denial Date:</b>	09/11/2015
<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: Montana

Certification(s)/Specialty: Preventive Medicine, Occupational 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 is a 49-year-old female worker with a date of injury 2-24-2015. The medical records indicated the injured worker (IW) was treated for mild head trauma; rule out shoulder pain and internal derangement. In the 8-4-15 and 9-1-15 progress notes, the IW reported pain and weakness in the bilateral lower extremities with numbness radiating from the legs into the toes, greater on the right. The IW was temporarily totally disabled. Objective findings on 8-4-15 and 9-1-15 included ambulation with a walker. She was able to undress and get on and off the exam table unassisted. She had pain with full range of motion of the bilateral shoulders, with right and left neck rotation and in the lumbar spine. Bulk, tone and power were 5 out of 5 for proximal and distal muscles and rapid, alternating and successive movements were performed in the upper extremities bilaterally without difficulty. Upper extremity strength, reflexes and sensation were normal. Treatments included physical therapy and acupuncture, which were somewhat beneficial. Previous electrodiagnostic testing, according to the records, was performed six years earlier. Electrodiagnostic testing of the bilateral upper extremities on 9-1-15 was normal. A Request for Authorization dated 8-17-15 was received for bilateral upper extremity electromyography and nerve conduction velocity studies for date of service 9-1-15. The Utilization Review on 9-11-15 non-certified the request for bilateral upper extremity electromyography and nerve conduction velocity studies, because the CA MTUS ACOEM Guidelines were not met.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Electromyogram (EMG)/Nerve conduction velocity of the bilateral upper extremities (DOS: 09-01-2015): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck, Electromyography and Nerve conduction studies.

**Decision rationale:** The MTUS states that electromyography (EMG) is recommended to clarify nerve root dysfunction in cases of suspected disc herniation preoperatively or before epidural injection. The ODG states that while cervical electrodiagnostic studies are not necessary to demonstrate a cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality or some problem other than a cervical radiculopathy, but these studies can result in unnecessary over treatment. Electrodiagnostic studies should be performed by appropriately trained Physical Medicine and Rehabilitation or Neurology physicians. Dissociation of NCS and EMG results into separate reports is inappropriate unless specifically explained by the physician. Performance and/or interpretation of NCSs separately from that of the needle EMG component of the test should clearly be the exception (e.g. when testing an acute nerve injury) rather than an established practice pattern for a given practitioner. The MTUS states that 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 3 or 4 weeks. The ODG states that nerve conduction studies (NCS, used interchangeably with nerve conduction velocities (NCV)) 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-neuropathic processes if other diagnoses may be likely based on the clinical exam. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy. Electrodiagnostic studies should be performed by appropriately trained Physical Medicine and Rehabilitation or Neurology physicians. Dissociation of NCS and EMG results into separate reports is inappropriate unless specifically explained by the physician. Performance and/or interpretation of NCSs separately from that of the needle EMG component of the test should clearly be the exception (e.g. when testing an acute nerve injury) rather than an established practice pattern for a given practitioner. In this case, the treating physician, on 8-4-15 and 9-1-15, noted normal strength, sensation and reflexes in the upper extremities. There is no documentation of other potential diagnoses for which upper extremity electrodiagnostic testing would be appropriate. With no documentation of objective or subjective radicular clinical findings, the request for Electromyogram (EMG)/Nerve conduction velocity of the bilateral upper extremities (DOS: 09-01-2015) is not medically necessary.