

Case Number:	CM15-0182513		
Date Assigned:	09/23/2015	Date of Injury:	06/30/2015
Decision Date:	10/28/2015	UR Denial Date:	09/09/2015
Priority:	Standard	Application Received:	09/16/2015

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

Certification(s)/Specialty: Emergency 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 63 year old female who sustained an industrial injury June 30, 2015, after hitting another car and possibly hitting the sun visor, without loss of consciousness but initially complaining of light headedness and neck spasm. Past history included gastric bypass. According to a primary treating physician's progress report dated September 3, 2015, the injured worker presented with frequent to moderate posterior head pain, frequent, moderate to severe and radiating neck pain, frequent and moderate to severe low back pain with radiation, frequent moderate pain and soreness of the bilateral shoulders and knees, and frequent to moderate pain and weakness of the left wrist. She reports some improvement with acupuncture treatment. Objective findings included; cervical spine tenderness to palpation, positive Kemp's test; lumbar spine-moderate tenderness, decreased dermatome sensation L3-S1 positive straight leg raise; positive right Braggard's, positive Ely's positive right bowstring and Valsalva; bilateral shoulders-moderate palpable tenderness, decreased range of motion, positive Apley's, Scratch and Apprehension tests; left wrist-palpable moderate tenderness with decreased range of motion, decreased grip strength, decreased dermatome sensations at C5-7, positive Tinel's and Phalen's; bilateral knees moderate palpable tenderness. Diagnoses are cervical spine multiple disc bulges with radiculopathy per MRI August 2015; thoracic sprain, strain; lumbar spine disc bulges with radiculopathy per MRI August 2015; left rotator cuff and labrum tears per MRI August 2015; left wrist sprain, strain; bilateral knees sprain, strain; hypertension. At issue is the request for authorization for EMG-NCS study of the bilateral upper extremities. A request for authorization dated August 7, 2015, requests an EMG-NCS (electromyography-nerve conduction) study of the bilateral upper extremities. A CT of the head dated June 30, 2015, impression is documented as no acute intracranial abnormality. A CT of the cervical

spine without contrast dated June 30, 2015, impression is documented as no acute displaced fracture of dislocation; mild-moderate cervical spondylosis. A lumbosacral spine x-ray dated June 2, 2015 (report present in the medical record) impression is documented as transitional lumbosacral segment; osteoarthritis of the lumbosacral spine. An MRI of the cervical spine dated August 28, (report present in the medical record) impression is documented as grade I posterior listhesis of C4 over C5; disc desiccation at C2-3 to C6-7 with associated loss of disc height at C2-3 to C6-7; straightening of the normal cervical lordosis; C2-C3 disc focal central which abuts the thecal sac; C3-C4 diffuse disc herniation which abuts the thecal sac; C4-C5 diffuse disc herniation which deforms the anterior aspect of the spinal cord; C5-C6 diffuse disc herniated which causes cord compression; C6-C7 broad-based disc herniation which indents the thecal sac. Reports of an MRI of the lumbar spine and left shoulder dated August 28, 2015 is present in the medical record. According to utilization review dated September 9, 2015, the request for EMG-NCS study of the bilateral upper extremities is non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG (Electromyography)/ NCS (Nerve Conduction Study) for 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, Treatment Index, Integrated Treatment, Disability Duration Guidelines, Pain (Chronic), Electrodiagnostic testing, Online Version (updated 09/03/15).

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

Decision rationale: The requested EMG (Electromyography) NCS (Nerve Conduction Study) for bilateral upper extremities is not medically necessary. American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 8, Neck and Upper Back Complaints, page 177-179, Special Studies and Diagnostic and Treatment Considerations, Special Studies and Diagnostic and Treatment Considerations, note Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. The injured worker has frequent to moderate posterior head pain, frequent, moderate to severe and radiating neck pain, frequent and moderate to severe low back pain with radiation, frequent moderate pain and soreness of the bilateral shoulders and knees, and frequent to moderate pain and weakness of the left wrist. She reports some improvement with acupuncture treatment. Objective findings included; cervical spine-tenderness to palpation, positive Kemp's test; lumbar spine-moderate tenderness, decreased dermatome sensation L3-S1 positive straight leg raise; positive right Braggard's, positive Ely's positive right bowstring and Valsalva; bilateral

shoulders-moderate palpable tenderness, decreased range of motion, positive Apley's, Scratch and Apprehension tests; left wrist-palpable moderate tenderness with decreased range of motion, decreased grip strength, decreased dermatome sensations at C5-7, positive Tinel's and Phalen's; bilateral knees- moderate palpable tenderness. With radiculopathy well documented on imaging study, the treating physician has not documented how this electrodiagnostic testing will change the injured worker's treatment plan. The treating physician has documented an MRI of the cervical spine dated August 28, (report present in the medical record) impression is documented as grade I posterior listhesis of C4 over C5; disc desiccation at C2-3 to C6-7 with associated loss of disc height at C2-3 to C6-7; straightening of the normal cervical lordosis; C2-C3 disc focal central which abuts the thecal sac; C3-C4 diffuse disc herniation which abuts the thecal sac; C4-C5 diffuse disc herniation which deforms the anterior aspect of the spinal cord; C5-C6 diffuse disc herniated which causes cord compression; C6-C7 broad-based disc herniation which indents the thecal sac. The criteria noted above not having been met, EMG (Electromyography)/NCS (Nerve Conduction Study) for bilateral upper extremities is not medically necessary.