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| Case Number: | CM15-0183026 | | |
| Date Assigned: | 09/23/2015 | Date of Injury: | 03/28/2005 |
| Decision Date: | 10/29/2015 | UR Denial Date: | 08/24/2015 |
| Priority: | Standard | Application Received: | 09/17/2015 |

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: North Carolina

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:

The injured worker is a 55-year-old male, who sustained an industrial injury on 3-28-2005. The medical records submitted for this review did not include documentation regarding the details of the initial injury and prior treatments to date. Diagnoses include multilevel cervical spine stenosis, lumbar discopathy with herniation and radiculopathy, status post cervical and lumbar spine surgeries. Currently, he complained of ongoing neck pain with radiation to bilateral upper extremities and the right hemibody. It was noted he tried to stand up and walk and almost fell down and broke his leg. On 8-17-15, the physical examination documented gait limitations and pain secondary to severe pain and numbness of the right leg, using a wheelchair for ambulation. The impression documented was central pain syndrome due to cord injury with right hemibody pain, superimposed cervical radiculitis with clinical feature suggestive of C7 radicular irritation bilaterally, left more than right. The appeal requested authorization for electromyogram and nerve conduction studies (EMG/NCS) of bilateral upper extremities. The Utilization Review dated 8-24-15, denied the request stating "the clinical notation do not document any changes in chronic, stable presentation of chronic myelopathy." Therefore, "the need for repeating diagnostic testing is not necessary." Per the American College of Occupational and Environmental Medicine (ACOEM) Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV of BUE: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The ACOEM chapter on neck and upper back complaints and special diagnostic studies states: Criteria for ordering imaging studies are: - Emergence of a red flag- Physiologic evidence of tissue insult or neurologic dysfunction- Failure to progress in a strengthening program intended to avoid surgery- Clarification of the anatomy prior to an invasive procedure Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies 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. 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 assessment may include sensory evoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected. If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps, including the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, compute tomography [CT] for bony structures). Additional studies may be considered to further define problem areas. The recent evidence indicates cervical disk annular tears may be missed on MRIs. The clinical significance of such a finding is unclear, as it may not correlate temporally or anatomically with symptoms. The provided documentation does not show any signs of emergence of red flags or subtle physiologic evidence of tissue insult or neurologic dysfunction. There is no mention of planned invasive procedures. There are no subtle neurologic findings listed on the physical exam. For these reasons criteria for special diagnostic testing has not been met per the ACOEM. Therefore, the request is not medically necessary.