

Case Number:	CM15-0188744		
Date Assigned:	09/30/2015	Date of Injury:	02/22/2013
Decision Date:	11/12/2015	UR Denial Date:	09/08/2015
Priority:	Standard	Application Received:	09/25/2015

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: Physical Medicine & Rehabilitation

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 57-year-old male with a date of industrial injury 2-22-2013. The medical records indicated the injured worker (IW) was treated for status post C5-6 anterior cervical discectomy and fusion with junctional level pathology; left shoulder impingement syndrome, rule out rotator cuff tear; and status post carpal tunnel release, right (2015) and left (1999). In the report (8-20-15), the IW reported intermittent pain in the cervical spine with radiation into the upper extremities rated 5 out of 10; constant left shoulder pain rated 10 out of 10, which was unchanged from the 6-18-15 notes; and constant pain in the bilateral wrists with tingling and numbness, rated 9 out of 10. Medications were Fenofibrate, Meloxicam, Amlodipine, Synthroid, Atenolol and Citalopram. On examination (8-20-15 notes), there was dysesthesia in the upper extremities with intact circulation and full and normal excursion of the fingers. Range of motion of the wrists and hands was full but painful and there was numbness in the right hand. X-rays of the hands and wrists (8-20-15) were stated to be within normal limits and x-rays of the cervical spine showed "no hardware failure" and "junctional level spondylosis at the C6-7 and C4-5, respectively". Treatments included cervical nerve root blocks, with no improvement; cervical fusion (2013); physical therapy, which helped the neck, but after right carpal tunnel release (2-2015), provided minimal improvement. MRI of the cervical spine on 2-10-15 was positive for postsurgical changes at C5-6 with left neural foraminal narrowing and multilevel osteophytosis. Electrodiagnostic testing of the bilateral upper extremities on 12-3-14 was positive for mild bilateral carpal tunnel syndrome and mild left and moderate right cubital tunnel syndrome; a previous study (7-22-13) was also abnormal. A Request for Authorization was received for bilateral upper extremity electromyography (EMG). The Utilization Review on 9-8-15 non-certified the request for bilateral upper extremity electromyography (EMG).

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral upper extremity EMG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and upper back - Electromyography (EMG).

MAXIMUS guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Special Studies.

Decision rationale: The current request is for Bilateral upper extremity EMG. Treatment history include C5-6 anterior cervical discectomy and fusion with junctional level pathology (04/07/14), carpal tunnel release, right (2015) and left (1999), physical therapy, injections, and medications. The patient is not working. ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11, page 260-262 states: "Appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful. NCS and EMG may confirm the diagnosis of CTS but may be normal in early or mild cases of CTS. If the EDS are negative, tests may be repeated later in the course of treatment if symptoms persist". ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11, page 260- 262 states: "Appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful. NCS and EMG may confirm the diagnosis of CTS but may be normal in early or mild cases of CTS. If the EDS are negative, tests may be repeated later in the course of treatment if symptoms persist." Per Initial Evaluation report dated 08/20/15, the patient presents with intermittent pain at the cervical spine, left shoulder, bilateral hands, and bilateral wrists. Examination of the c-spine revealed positive axial compression and Spurling's test, ROM is limited, and there is dysesthesia in the upper extremities. Examination of the bilateral wrist/hands showed full but painful ROM and numbness in the right hand. Review of the records show the patient had an EMG/NCV on 07/22/13 which showed moderate left CTS. A repeat study was performed on 12/03/14 which showed mild bilateral CTS, and mild left and moderate right cubital tunnel syndrome. X-rays of the c-spine was obtained which showed spondylosis at the levels C6-7 and C4-5. X-rays of the left shoulder showed some hypertrophy of the distal clavicle. X-rays of the bilateral/wrists hands were within normal limits. The treater states that neurodiagnostic studies would be advised at this point and request an EMG/NCV of the bilateral upper extremities. In this case, the patient continues to have residual pain and radiating symptoms. However, electrodiagnostic studies were already done on two different occasions. Both studies were done prior to the left CTR in 2015, but bilateral wrist/hand x-rays obtained on 08/20/15 were within normal limits. Therefore, the request repeat EMG is not medically necessary.