

<b>Case Number:</b>	CM15-0204888		
<b>Date Assigned:</b>	10/21/2015	<b>Date of Injury:</b>	01/19/2015
<b>Decision Date:</b>	12/03/2015	<b>UR Denial Date:</b>	10/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/19/2015

### 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: Georgia

Certification(s)/Specialty: Anesthesiology, Pain Management

### 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 29-year-old male with a date of industrial injury 1-19-2015. The medical records indicated the injured worker (IW) was treated for cervical radiculopathy; lumbosacral radiculopathy; and shoulder impingement. In the progress notes (7-13-15, 9-21-15), the IW reported chronic pain in the cervical and lumbar spine and right shoulder. He stated he had cramping in the right arm and occasional numbness and tingling in the right shoulder, arm and hand with clicking, grinding and locking of the right shoulder. The cervical spine and lumbar spine pain was intermittent and aggravated by prolonged sitting and driving. The pain caused him difficulty with showering, dressing, grooming and house chores. On examination (7-13-15 notes), there was spasm and tenderness over the cervical and lumbar paravertebral muscles and decreased ranges of motion. Deep tendon reflexes of the upper extremities were 2+ bilaterally and were equal at the knee and ankle joints. Motor strength was 5 out of 5 in the bilateral upper and lower extremities. Sensation was decreased with pain to the right middle finger and in the right lateral leg and mid-foot, but was otherwise intact. Heel and toe walking was painful. Seated and supine straight leg raising was negative for back pain at 90 degrees. Treatments included physical therapy, with temporary relief; shoulder injection (4-2015), which helped for a few days; and Lidopro, Mobic and Relafen. The IW was on modified work duty. Electrodiagnostic testing of the bilateral upper and lower extremities was requested to rule out peripheral nerve entrapment. A Request for Authorization was received for EMG-NCV (electromyography-nerve conduction velocity) of the bilateral upper extremities and EMG-NCV (electromyography-nerve conduction velocity) of the bilateral lower extremities. The Utilization Review on 10-14-15 non-

certified the request for EMG-NCV of the bilateral upper extremities and bilateral lower extremities.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **EMG (electromyography) and NCV (nerve conduction velocity) of the bilateral upper extremities: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Special Studies, Summary.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Upper Extremity Pain: Diagnostic Consideration.

**Decision rationale:** EMG (electromyography) and NCV (nerve conduction velocity) of the bilateral upper extremities is not medically necessary. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures). Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with cervical or upper extremity symptoms lasting more than three or four weeks. The physical exam did not exhibit motor or neurological deficit; therefore, the request is not medically necessary.

#### **EMG (electromyography) and NCV (nerve conduction velocity) of the bilateral lower extremities: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back (updated 9/22/15) Nerve conduction studies (NCS).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Pain: Diagnostic Consideration.

**Decision rationale:** EMG (electromyography) and NCV (nerve conduction velocity) of the bilateral lower extremities is not medically necessary. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss

with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures). 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. The physical exam did not exhibit motor or neurological deficit; therefore, the request is not medically necessary.