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| <b>Case Number:</b>   | CM15-0207202 |                              |            |
| <b>Date Assigned:</b> | 10/26/2015   | <b>Date of Injury:</b>       | 12/11/2014 |
| <b>Decision Date:</b> | 12/08/2015   | <b>UR Denial Date:</b>       | 10/09/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 10/21/2015 |

### 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, Oregon, Idaho

Certification(s)/Specialty: Orthopedic Surgery

### 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 50 year old male, who sustained an industrial-work injury on 12-11-14. He reported initial complaints of neck, upper, lower back, and left shoulder pain. The injured worker was diagnosed as having left shoulder impingement, C4-C7 disc protrusions with mild to moderate spinal stenosis with suspected impingement of the right neural roots, L4-5 disc protrusion with mild to moderate spinal stenosis and impingement of the bilateral neural canal, T12 vertebral body compression deformity, L5-S1 posterior bulge, mild spinal stenosis and impingement of L5 nerve root, and cervical radiculopathy. Treatment to date has included medication and diagnostics. MRI results were reported on 6-4-15 of the cervical spine demonstrated hypolordosis, DDD (degenerative disc disease), C3-4 posterior disc bulge with mild spinal stenosis, C4-5 posterior disc protrusion, mild to moderate spinal stenosis, and possible mild compression of the spinal cord, C5-6 posterior disc protrusion with spinal stenosis, spinal cord compression, and impingement of the right C6 nerve root at the right neural canal, and T1-2 posterior disc protrusion. Currently, the injured worker complains of pain in the neck and shoulder that was rated 7-8 in severity. Meds include Tramadol and Tizanidine reduce pain to 5 out of 10 and allows him to walk longer and stand 30 minutes. He is on work restrictions. Per the primary physician's orthopedic report on 9-15-15, cervical exam notes moderate discomfort with range of motion over C5-6 and C8-7 and over the paraspinal musculature, mild spasms. The Request for Authorization requested service to include EMG (electromyography) of the BUE (bilateral upper extremities). The Utilization Review on 10-9-15 denied the request for EMG (electromyography) of the BUE (bilateral upper extremities).

## IMR ISSUES, DECISIONS AND RATIONALES

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

**EMG of the BUE:** 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).

**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.

**Decision rationale:** CA/MTUS ACOEM Neck and Upper Back Chapter, page 178, states, 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, computed tomography [CT] for bony structures). The ODG neck section states the nerve conduction studies 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. (Utah, 2006) (Lin, 2013) While cervical electrodiagnostic studies are not necessary to demonstrate a cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality, diabetic neuropathy, or some problem other than a cervical radiculopathy, with caution that these studies can result in unnecessary over treatment. Studies have not shown portable nerve conduction devices to be effective. In this case, the worker was injured more than a year ago and has multilevel cervical spondylosis. The on 9/15/15 states that the injured worker clearly cervical radiculopathy however, no objective symptoms are reported. Specific nerve and muscle testing of the upper extremities should be documented to support the diagnosis of radiculopathy. In addition, the documentation does not support any diagnostic ambiguity, which an EMG would help to clarify. Based on the cited guidelines, the request is not medically necessary.