

Case Number:	CM15-0209472		
Date Assigned:	10/28/2015	Date of Injury:	12/17/2012
Decision Date:	12/09/2015	UR Denial Date:	10/09/2015
Priority:	Standard	Application Received:	10/23/2015

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 46 year old male with an industrial injury date of 12-17-2012. Medical record review indicates he is being treated for status post anterior cervical discectomy 01-20-2015 with a partial vertebrectomy fusion with plate, recurrence of upper extremity numbness, tingling and weakness and low back pain and lumbar sprain. In the 09-23-2015 neurosurgical follow up evaluation the injured worker noted some improvement of his arm symptoms, but continued to have some symptoms on his hands "and intermittent numbness is best described." Prior treatments included medications and physical therapy. Prior diagnostics include CT of neck (07-31-2015) read as follows: There is straightening of normal cervical lordosis. At the cervical 5-cervical 6 disc space, interbody screws and metallic fixation plate and a solid incorporation of fusion graft is noted. There is a 1-2 mm left lateral bridging osteophyte and hypertrophic changes left uncovertebral joint without significant central canal stenosis and only minimal proximal left foraminal stenosis is present. Findings which are stable. Physical exam (09-23-2015) noted pain free range of motion of the neck. Neurological examination of the upper and lower extremities reveals reflexes are 2 and symmetric. Motor strength was 5 out of 5. Sensation with the pinwheel was intact at the time of exam. Exam of hands noted no discoloration and no changes on his skin or nail beds. There was no redness or hypersensitivity. On 10-09-2015 the request for EMG-NCV of bilateral upper extremities was non-certified by utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG (Electromyography)/ NCV (Nerve Conduction Velocity) study of BUE (bilateral upper extremities): Upheld

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

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, compute 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 is 46 years old and was injured in 2012. He is status post C5-6 ACDF on 1/20/15 but is being treated for persistent intermittent numbness in his hands without any objective findings noted on exam on 9/23/15. He only reports subjective symptoms of numbness without objective findings to suggest ongoing pathology which would benefit from further cervical spine surgery. In addition, there are no objective findings to suggest peripheral nerve compression and there is no documentation of attempted conservative management of ongoing symptoms. Therefore, the request is not medically necessary.