

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM15-0029492 | | |
| Date Assigned: | 02/23/2015 | Date of Injury: | 09/21/2010 |
| Decision Date: | 04/08/2015 | UR Denial Date: | 01/26/2015 |
| Priority: | Standard | Application Received: | 02/17/2015 |

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: 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:

The injured worker (IW) is a 56-year-old female who sustained an industrial injury on 09/21/2010. She has reported pain in the cervical spine, bilateral shoulder pain, and left elbow pain which the IW rated as 8/10 on a pain scale. Diagnoses include cervical myoligamentous injury with left upper extremity radicular symptoms status post arthroscopic surgery of the left shoulder (11/16/2012), status post left carpal tunnel release and left lateral and medial epicondylitis surgery (07/21/2011), status post left ulnar nerve surgery (07/20/2011, and reactionary depression/anxiety. Treatments to date include medications, medication management, physical therapy and acupuncture. A progress note from the treating provider dated 11/13/2014 indicates tenderness to palpation bilaterally with increased muscle rigidity on exam of the posterior cervical musculature. Numerous trigger points were palpable and tender throughout the cervical paraspinal muscles. She has a positive left Spurling's sign. There is decreased cervical range of motion in all planes. A cervical spine MRI revealed a 3mm disc protrusions at C4-5 and C6-7 and 2 mm disc protrusions at C3-4 and C5-6 with bilateral neural foraminal stenosis at C5-6. Subjectively the patient is in a great deal of pain and is requiring escalating doses of her oral analgesic medication. The treatment plan included further testing, a cervical MRI, and upper extremity EMG were requested along with a cervical epidural steroid injection and a left shoulder MR arthrogram. On 01/26/2015 Utilization Review non-certified a request for repeat bilateral upper extremity EMG. The ACOEM guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Repeat bilateral upper extremity EMG: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints Page(s): 177-178, 207-208. Decision based on Non-MTUS Citation Official Disability Guidelines Neck and Upper Back Chapter MRI.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260-262. Decision based on Non-MTUS Citation Official disability guidelines Low back chapter, Electrodiagnostic Studies.

Decision rationale: This patient presents with cervical discopathy and left upper extremity radiculopathy. The patient is status post left carpal tunnel release from July 21, 2011 and status post left ulnar nerve surgery from July 20, 2012. The treater is requesting a REPEAT BILATERAL UPPER EXTREMITY EMG. The RFA from 12/18/2014 shows a request for upper extremity EMG. The patient's date of injury is from 09/21/2010 and her current work status was not made available. The ACOEM guidelines page 262 on EMG/NCV states that appropriate studies, EDS, may help differentiate between CTS and other condition such as cervical radiculopathy. In addition, ODG states that electrodiagnostic testing includes testing for nerve conduction velocities and possibly the addition of electromyography EMG. Electromyography and nerve conduction velocities including H-reflex test may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms or both, lasting more than 3 or 4 weeks. The EMG of the bilateral upper extremities from September 18, 2013 showed an abnormal EMG/NCS of the bilateral upper extremities. There is evidence of bilateral median neuropathy at the wrist of mild severity on the right, moderate severity on the left. There is also evidence of left posterior interosseous neuropathy affecting the left EIP muscle. There was no evidence of cervical radiculopathy or myopathy. The examination from 12/18/2014 shows numerous trigger points throughout the cervical paraspinal muscles. The patient has decreased range of motion with obvious muscle guarding. Positive left Spurling's sign, positive foraminal compression with ipsilateral extension to the left radicular pains to the left medial scapular region and arm. Sensory exam with Wartenberg pinprick wheel is decreased on the left lateral arm and forearm as well as the left second, third, and fourth digits in comparison to the right upper extremity. The treater references the cervical spine MRI that revealed 3 mm disc protrusion at C4-5 and C6-7 and 2 mm disc protrusion at C3-4 and C5- 6 with bilateral neural foraminal stenosis at C5-6. In the case, given the patient's significant clinical findings an updated bilateral upper extremity EMG is appropriate. The request IS medically necessary.