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| <b>Case Number:</b>   | CM15-0216271 |                              |            |
| <b>Date Assigned:</b> | 11/06/2015   | <b>Date of Injury:</b>       | 05/24/2014 |
| <b>Decision Date:</b> | 12/18/2015   | <b>UR Denial Date:</b>       | 10/19/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 11/03/2015 |

### 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, Indiana, New York  
 Certification(s)/Specialty: Internal Medicine

### 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 24 year old male, who sustained an industrial injury on 5-24-2014. His diagnosis at that time included, left shoulder dislocation, and a scalp laceration. He reported left- sided neck pain with occasional numbness of all fingers on hands, left shoulder, and back pain, which interfered with his activities of daily living. He also reports neck pain that worsens with movement, rating pain sometimes 4 out of 10 and 9 out of 10. Subjective findings continue to include left shoulder and lumbar pain. On 9-25-2015, the injured worker reported improvement in his neck and shoulder with mild pain and some numbness and tingling in his hands. According to provider documentation dated 9-25-2015, objective findings were notable for no neurological deficits or new findings. An MRI of the thoracic spine and a CT of the thoracic spine was performed on 5-25-2014, revealing low lung volumes, mild bibasilar changes, and mild patchy opacity of the left lung apex, with normal alignment and no fracture present. Treatments to date have included Norco 7.5/325mgs twice a day, a thoracic spine brace and a left shoulder sling for a diagnosis of left shoulder impingement and lumbar strain. An MRI scan of the cervical spine dated 10-21-2014, revealed a disc bulge at C3-C4, C5-C6 (cervical), and EMG/nerve conduction study was unremarkable. Treatments to date have included shoulder injections, left shoulder surgery, Ibuprofen, Norco, Naprosyn, alternating hot/cold therapies, and, physical and chiropractic therapies. The injured worker stated the shoulder surgery has provided partial relief, where he has gained more movement and reports some pain. The Utilization Review determination dated 10-19-2015 did not certify treatment/service requested for EMG/NCS bilateral upper extremity (cervical).

## IMR ISSUES, DECISIONS AND RATIONALES

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

**EMG/NCS BUE cervical:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, Cervical & Thoracic Spine Disorders, Diagnostic Investigations.

**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 section, EMG/NCV.

**Decision rationale:** Pursuant to the Official Disability Guidelines, EMG/NCV of the bilateral upper extremities cervical is not medically necessary. The ACOEM states (chapter 8 page 178) unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. 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-neuropathies if other diagnoses may be likely based on physical examination. Nerve conduction studies are recommended in patients with clinical signs of carpal tunnel syndrome who may be candidates for surgery. EMG is recommended only in cases where diagnosis is difficult with nerve conduction studies. While cervical electrodiagnostic studies are not necessary to demonstrate his cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality, diabetic property or some problem other than cervical radiculopathy. In this case, the injured worker's working diagnoses are cerebral concussion; cervical spine sprain; history left shoulder dislocation; left shoulder sprain strain; status post A/S; left pectoral pain; bilateral hand sprain, numbness rule out CTS; and lumbosacral sprain with sciatica improving. Date of injury is May 24, 2014. Request for authorization is October 12, 2015. According to an August 7, 2014 progress note, the injured worker was certified and underwent EMG/nerve conduction velocity study of the left upper extremity. The hard copy of the result was not present in the medical record. According to a September 29, 2015 progress note, subjective complaints include pain and ongoing left shoulder pain, improved, 3/10. Chiropractic treatment has reduced pain. Additional complaints are low back pain with numbness and tingling of the bilateral hands. The treating provider is requesting an updated EMG/NCV to further evaluate for neuropathy versus radiculopathy. Objectively, there is no physical examination in the medical record of the neck and upper extremities. There is no neurologic evaluation. There is no documentation indicating anticipated surgery. Based on the clinical information in the medical record, peer-reviewed evidence-based guidelines, no physical examination or neurologic evaluation of the cervical spine and or upper extremities, no neurologic deficits documented, no documentation of the prior EMG/NCV performed August 7, 2014 and no clinical indication or rationale for the EMG/NCV other than updating the prior result, EMG/NCV of the bilateral upper extremities cervical is not medically necessary.