

<b>Case Number:</b>	CM15-0047437		
<b>Date Assigned:</b>	03/26/2015	<b>Date of Injury:</b>	06/16/2014
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	03/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/12/2015

### 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: North Carolina

Certification(s)/Specialty: Family Practice

### 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 42-year-old female, who sustained an industrial injury on June 16, 2014. She reported neck, bilateral shoulder, and bilateral wrist injuries. The injured worker was diagnosed as having rule out cervical, thoracic, and lumbar herniated nucleus pulposus, cervical radiculopathy, and lumbar radiculopathy. Treatment to date has included x-rays, physical therapy for the neck and upper extremities, bilateral wrist splints, urine drug screening, work modifications, and medications including oral pain, topical pain, muscle relaxant, antidepressant, and non-steroidal anti-inflammatory. On January 23, 2015, the injured worker complains of constant stabbing neck pain over her shoulders into her right upper back and constant stabbing wrist pain with tingling in the top of the hand near the fifth finger. The pain radiates up to her forearms at times. In addition, she has constant stabbing pain in her right low back/right hip with radiation down the right lower extremity to the ankle level. She has right calf pain. The physical exam revealed tenderness to palpation and decreased range of motion of the cervical spine. Sensation of the upper extremities was intact, motor strength of the upper extremities was limited by pain and with give-way weakness, hyporeflexic biceps and brachioradialis reflexes bilaterally, normoreflexic triceps reflexes, a positive right Spurling's causing right shoulder pain, negative left Spurling's, and negative bilateral Tinel's. The treatment plan includes electromyography/nerve conduction study of the bilateral upper extremities.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**EMG/NCS of the bilateral upper extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173-174.

**Decision rationale:** The ACOEM chapter on neck and upper back complaints and special diagnostic studies states: Criteria for ordering imaging studies are: Emergence of a red flag. Physiologic evidence of tissue insult or neurologic dysfunction. Failure to progress in a strengthening program intended to avoid surgery. Clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies 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. 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). Additional studies may be considered to further define problem areas. The recent evidence indicates cervical disk annular tears may be missed on MRIs. The clinical significance of such a finding is unclear, as it may not correlate temporally or anatomically with symptoms. The provided documentation does not show any signs of emergence of red flags or subtle physiologic evidence of tissue insult or neurologic dysfunction. There is no mention of planned invasive procedures. There are no subtle neurologic findings listed on the physical exam. For these reasons criteria for special diagnostic testing has not been met per the ACOEM. Therefore, the request is not medically necessary.