

<b>Case Number:</b>	CM15-0055168		
<b>Date Assigned:</b>	03/30/2015	<b>Date of Injury:</b>	02/08/2007
<b>Decision Date:</b>	05/04/2015	<b>UR Denial Date:</b>	02/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/23/2015

### 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: 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 was a 53 year old male, who sustained an industrial injury, April 14, 2005, February 8, 2007 and continuous trauma from 1985 through January 2009. The injured worker previously received the following treatments steroid epidural injection of left and right sacroiliac joint, random toxicology laboratory studies, bilateral L4, L5 and S1 facet Rhizotomy, lumbar spine MRI, bilateral medial branch block of L4, L5 and S1 and bilateral carpal tunnel release in 2012, (electro diagnostic studies and nerve conduction studies) of the upper extremities on October 1, 2014. The injured worker was diagnosed with lumbar facet syndrome, intractable low back pain, lumbar disc disease bilateral sacroiliac joint arthropathy and lumbar radiculopathy. According to progress note of December 15, 2014, the injured workers chief complaint was severe cervical, thoracic and lumbar spine pain. The injured worker rated the pain at 8 out of 10; 0 being no pain and 10 being the worse pain. The physical exam noted decreased range of motion to the cervical spine, thoracic spine and lumbar spine. The sensory exam of the upper extremities was normal. According to the documentation submitted for review the injured worker had EMG/NCS (electro diagnostic studies and nerve conduction studies) of the upper extremities on October 1, 2014. The treatment plan included EMG/NCS (electro diagnostic studies and nerve conduction studies) to the bilateral upper extremities.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Bilateral Upper Extremity EMG (electromyogram) / NCV (nerve conduction velocity) tests:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 8 Neck and Upper Back Complaints Page(s): 177-178, 260-262.

**Decision rationale:** Based on the 12/15/14 progress report provided by treating physician, the patient presents with cervical pain rated 8/10. The request is for Bilateral Upper Extremity Emg (Electromyogram)/NCV (Nerve Conduction Velocity) Test. Patient is status post cervical spine fusion in 2009, and bilateral carpal tunnel release in 2012. RFA not provided. Patient's diagnosis on 12/15/14 included cervical disk protrusion and thoracic outlet syndrome. Physical examination to the cervical spine on 12/15/14 revealed tenderness to the bilateral paracervical muscles bilaterally and decreased range of motion in all planes. Patient uses Lidoderm patches and topical creams. Patient is permanently partially disabled, per treater report dated 12/15/14. MTUS/ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8, Neck and Upper Back Complaints, Special Studies and Diagnostic and Treatment Considerations, 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. ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11, page 260-262 states: Appropriate electro diagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful. NCS and EMG may confirm the diagnosis of CTS but may be normal in early or mild cases of CTS. If the EDS are negative, tests may be repeated later in the course of treatment if symptoms persist. UR letter dated 02/24/15 states: "in regard to electro diagnostic testing, noted is a September 2014 certification for EDS of all four extremities and their related cervical and lumbar paraspinal muscles." This patient presents with neck pain and is status post carpal tunnel release 2012. There are no radicular or peripheral neuropathy complaints or clinical findings. Medical records include EMG/NCV study of the lower extremity dated 10/17/14, and EMG/NCV of the upper extremities dated 10/01/14, which revealed normal findings and no electro diagnostic evidence for a peripheral polyneuropathy. There is no explanation as to why a repeat study is needed, and there has not been any change in the patient's clinical presentation. Therefore, the request Is Not medically necessary.