

Case Number:	CM15-0084217		
Date Assigned:	05/06/2015	Date of Injury:	01/22/2007
Decision Date:	06/05/2015	UR Denial Date:	04/09/2015
Priority:	Standard	Application Received:	05/01/2015

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:

This is a 39-year-old female with a January 22, 2007 date of injury. At the time (March 24, 2015) of the most recent evaluation submitted for review, there is documentation of subjective findings (headache rated at 8/10; neck pain rated at 8/10; bilateral shoulder pain rated at 9/10; bilateral forearm/wrist/hand pain rated at 7/10; lower back pain rated at 8/10; right leg pain rated at 7/10; pain that was were unchanged since the last visit; progressive left leg weakness; radiating neck pains extending to the left forearm and hand (thumb, ring and pinky fingers), objective findings (palpable tenderness at the left cervical dorsal, upper thoracic, right cervical dorsal, right cervical, cervical, left cervical, left lumbar, left sacroiliac, sacral, right sacroiliac, and right lumbar; decreased range of motion of the cervical spine; decreased range of motion of the lumbar spine; decreased range of motion of the bilateral upper extremities; decreased muscle strength of the right upper extremity and right lower extremity) and current diagnoses (cervical intervertebral disc disorder with myelopathy; lumbar intervertebral disc disorder with myelopathy; periartthritis of the shoulder; synovitis/tenosynovitis). Treatments to date included lumbar spine discectomy, electromyogram that showed right carpal tunnel syndrome, magnetic resonance imaging of the cervical spine, lumbar spine, and bilateral shoulders, lumbar spine epidurals with two days of relief, and physiotherapy that was discontinued due to increased pain. The treating physician documented a plan of care that included electromyogram/nerve conduction velocity 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/NCV of The Bilateral Upper Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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 There is evidence of neurologic dysfunction on exam. There is no mention of planned invasive procedures. There are no subtle neurologic findings listed on the physical exam. Conservative treatment has not been exhausted. For these reasons criteria for special diagnostic testing has not been met per the ACOEM. Therefore, the request is not medically necessary.