MAXIMUS Federal Services

Case Number:	CM14-0151629		
Date Assigned:	09/19/2014	Date of Injury:	07/19/2013
Decision Date:	11/12/2014	UR Denial Date:	08/26/2014
Priority:	Standard	Application Received:	09/17/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 40-year-old female who reported an injury on 07/19/2013 due to an unknown mechanism. Diagnoses were low back pain, possible lumbar radiculitis, neck pain, lumbar discogenic pain, cervical discogenic pain, possible cervical facet pain, left shoulder pain, myofascial pain, thoracic pain, thoracic discogenic pain, and chronic pain syndrome. The physical examination dated 08/12/2014 revealed complaints of neck, left shoulder, and low back pain. It was reported that the injured worker continued to find her medications helpful and well tolerated. The injured worker reported having pain over the left side of her body, from the neck to her elbow, mid back, low back, and left thigh that was described as aching. It was also reported that she experienced intermittent numbness and weakness in her left upper and lower extremities. The pain was rated a 9/10 to 10/10 without medications and 7/10 to 8/10 with medications. It was also reported that her pain was worse since her last appointment. The injured worker denied any new symptoms or neurological changes. The examination of the cervical and thoracic spine revealed a 5-/5 left upper extremity strength and 5/5 right upper extremity strength. Sensation was intact and equal. Deep tendon reflexes were 1+ and symmetric. There was tenderness over the cervical and thoracic paraspinals on the left. There was tenderness over the facet joints on the left. The cervical spine range of motion was reduced on all planes. MRI of the cervical spine dated 08/05/2014 revealed straightening of the normal cervical lordosis, which may be secondary to patient positioning or muscle spasms. Disc desiccation with 1 mm to 2 mm diffuse disc bulges were noted at the C4-5 and C5-6 levels without cervical spinal cord or nerve root compression identified. The injured worker had an AME report which recommended bilateral upper and lower EMG/NCS. The goal of the EMG/nerve conduction study was to assess for nerve root dysfunction, and also upper extremity

entrapment neuropathy. It was also reported that this was to be used to evaluate for denervation or chronic changes in nerve root distribution. The Request for Authorization was not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG for bilater upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines criteria for EMG/ NCV.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

Decision rationale: The decision for EMG for bilater upper extremities is not medically necessary. California ACOEM 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, and 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 neurological examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography (EMG) and nerve conduction velocity (NCV), including H-reflex test, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than 3 weeks or 4 weeks. The assessment may include sensory evoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected. The medical guidelines state unequivocal findings of a specific nerve compromise on the neurologic examination are sufficient evidence to warrant studies. There was no emergence of a red flag. There were no specific dermatomal/myotomal distribution deficits reported, and the provider did not report that the injured worker had failure to progress in a strengthening program. The injured worker denied any new symptoms or neurological changes. The clinical information submitted for review does not provide evidence to justify the decision for EMG for bilateral upper extremities. Therefore, this request is not medically necessary.

NCV for the bilateral upper extremities: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

Decision rationale: The decision for NCV for the bilateral upper extremities is not medically necessary. California ACOEM 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, and 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 neurological examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography (EMG) and nerve conduction velocity (NCV), including H-reflex test, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than 3 weeks or 4 weeks. The assessment may include sensory evoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected. The medical guidelines state unequivocal findings of a specific nerve compromise on the neurologic examination are sufficient evidence to warrant studies. There was no emergence of a red flag. There were no specific dermatomal/myotomal distribution deficits reported, and the provider did not report that the injured worker had failure to progress in a strengthening program. The injured worker denied any new symptoms or neurological changes. The clinical information submitted for review does not provide evidence to justify the decision for NCV for bilateral upper extremities. Therefore, this request is not medically necessary.