

<b>Case Number:</b>	CM14-0161545		
<b>Date Assigned:</b>	10/07/2014	<b>Date of Injury:</b>	01/28/2013
<b>Decision Date:</b>	11/04/2014	<b>UR Denial Date:</b>	09/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/01/2014

### 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 Occupational Medicine and is licensed to practice in California. 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:

Injured worker is a male with date of injury 1/28/2013. Per neurological evaluation dated 8/28/2014, the injured worker complains of left neck pain, constant, and associated with range of motion. The pain is described as cramping. The pain is spreading down to the left arm to the fifth finger, described as constant, and associated with constant numbness in the left fifth finger and medial forearm. He complains of weakness in the left arm, and he is left handed. He is unable to sleep due to pain. He complains of constant burning pain in the left shoulder blade. He complains of decreased appetite. He complains of lightheadedness occurring daily with increased pain in the left arm. He had one episode of loss of consciousness but does not recall when. He attributes the loss of consciousness to increased pain. He complains of dizziness with sudden change in position such as getting up from a chair or squatting position. On examination cervical spine range of motion is flexion 60 degrees, extension 45 degrees, rotation to the right and left 60 degrees each side. Lhermitte sign is negative. Paravertebral muscle tenderness is slight, bilaterally. There is slight occipital notch tenderness. Left shoulder flexion is 175 degrees, abduction 176 degrees, internal rotation 30 degrees, external rotation 80 degrees, adduction 30 degrees, and extension 30 degrees. Left upper extremity deltoid and biceps strength is 5-/5, otherwise muscle testing is 5/5 throughout. There is tenderness at the left elbow without Tinel sign at the left cubital tunnel. There is decreased light touch in the bilateral lower extremities in the stocking distribution. Deep tendon reflexes are 1+ upper extremities and absent at the knees and ankles. Babinski is negative. Coordination is intact. Gait is normal. Romberg is negative and he has normal tandem walk. Diagnoses include 1) left shoulder impingement syndrome status post surgery 8/28/2013 with mild residual limitation in range of motion and persistent pain 2) neck pain with evidence of subacute to chronic left C7-8 radiculopathy based on EMG/NCS of

the left upper extremity 2/24/2014 3) lack of reflexes in bilateral lower extremities, decreased sensation in the bilateral lower extremities suggests peripheral neuropathy.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Bilateral Lower Extremities EMG/NCV: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines): Diabetes

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Nerve Conduction Studies (NCS) Section, Pain Chapter, Monofilament Testing Section

**Decision rationale:** Per the MTUS Guidelines, EMG may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. Per the ODG, nerve conduction studies are not recommended because there is minimal justification of performing nerve conduction studies when a patient is presumed to have symptoms based on radiculopathy. The injured worker does not have low back or lower extremity complaints. On examination, it was noted that the injured worker had reduced sensation to bilateral lower extremities in stocking distribution. The requesting physician reports that these tests are being requested to evaluate for a global peripheral neuropathy. Per the ODG, several tests are used to detect peripheral neuropathy, including vibration perception, application of warmth and cold, and nerve conduction studies, which are assumed to be the reference standard. Electro diagnostic tests can be complex, expensive, and time consuming, which hampers their widespread use, especially in primary care, where for most patients peripheral neuropathy is diagnosed and treated. Monofilament testing is an inexpensive, easy-to-use, and portable test for assessing the loss of protective sensation, and it is recommended by several practice guidelines to detect peripheral neuropathy in otherwise normal feet. Sensitivity of the 5.07/10-g monofilament to detect peripheral neuropathy ranged from 41% to 93%, and specificity ranged from 68% to 100%. Despite the frequent use of monofilament testing, little can be said about the test accuracy for detecting neuropathy in feet without visible ulcers. The diagnosis of peripheral neuropathy can be made only after a careful clinical examination with more than 1 test, as recommended by the American Diabetes Association. Tests for this clinical examination are vibration perception (using a 128-Hz tuning fork), pressure sensation (using a 10-g monofilament at least at the distal halluces), ankle reflexes, and pinprick. When in doubt, a nerve conduction test might be necessary to establish a firm diagnosis. Medical necessity of EMG/NCV has not been established. Less expensive tests should be performed first, and then NCV may need to be considered if there is a need to establish a firm diagnosis. The cause of peripheral neuropathy has also not been approached by the requesting physician. The request for bilateral lower extremities EMG/NCV is determined to not be medically necessary.

#### **Right Upper Extremities EMG/NCV: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines): Diabetes

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Monofilament Testing Section

**Decision rationale:** The MTUS Guidelines recommend the use of electromyography (EMG) and nerve conduction velocity (NCV) to help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. Per the ODG, several tests are used to detect peripheral neuropathy, including vibration perception, application of warmth and cold, and nerve conduction studies, which are assumed to be the reference standard. Electrodiagnostic tests can be complex, expensive, and time consuming, which hampers their widespread use, especially in primary care, where for most patients peripheral neuropathy is diagnosed and treated. Monofilament testing is an inexpensive, easy-to-use, and portable test for assessing the loss of protective sensation, and it is recommended by several practice guidelines to detect peripheral neuropathy in otherwise normal feet. Sensitivity of the 5.07/10-g monofilament to detect peripheral neuropathy ranged from 41% to 93%, and specificity ranged from 68% to 100%. Despite the frequent use of monofilament testing, little can be said about the test accuracy for detecting neuropathy in feet without visible ulcers. The diagnosis of peripheral neuropathy can be made only after a careful clinical examination with more than 1 test, as recommended by the American Diabetes Association. Tests for this clinical examination are vibration perception (using a 128-Hz tuning fork), pressure sensation (using a 10-g monofilament at least at the distal halluces), ankle reflexes, and pinprick. When in doubt, a nerve conduction test might be necessary to establish a firm diagnosis. Medical necessity of EMG/NCV has not been established. Less expensive tests should be performed first, and then NCV may need to be considered if there is a need to establish a firm diagnosis. There cause of peripheral neuropathy has also not been approached by the requesting physician. The request for Right upper extremities EMG/NCV is determined to not be medically necessary.

**Labs: TSH, FE-Panel, B12 level, ESR:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Lab Tests Online

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 1 Prevention Page(s): 2.

**Decision rationale:** The MTUS Guidelines recommends the use of laboratory measurements to make a diagnosis. The requesting physician suspects that the injured worker may have a global peripheral neuropathy. These laboratory tests are reasonable in the assessment of peripheral neuropathy. The request for TSH, FE-Panel, B12 level, ESR is determined to be medically necessary.