

Case Number:	CM14-0178296		
Date Assigned:	10/31/2014	Date of Injury:	11/01/2009
Decision Date:	01/06/2015	UR Denial Date:	09/24/2014
Priority:	Standard	Application Received:	10/27/2014

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 Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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 patient is a 53-year-old woman who sustained a work-related injury on November 1, 2009. Subsequently, she developed chronic wrist, lower extremities, elbow joints, and shoulder pain. MRI dated July 15, 2013 showed moderate to severe bilateral foraminal narrowing at L4-5, moderate neural foraminal narrowing at left L3-4, and severe degenerative disc disease T12-L1 with mild/moderate central canal stenosis. MRI of the left shoulder showed rotator cuff tendinopathy and bursitis without tear. The patient had an EMG/NCV test done on July 16, 2013 and showed bilateral carpal tunnel syndrome more prominent on the left and moderate ulnar neuropathy on the right side. On December 2013, the patient underwent a left carpal tunnel release. According to the progress report dated September 8, 2014, the patient complained of increased burning pain of the left wrist and hand with more weakness. She rated her pain as a 6/10. The patient also complained of low back pain with left greater than right with lower extremity symptoms. Objective findings include moderately positive Tinel's/Phalen's left. Lumbar range of motion was limited by pain. Positive straight leg raise left and right for pain to foot. The patient was diagnosed with left shoulder impingement and bilateral foraminal stenosis, L3-4 and L4-5. The provider requested authorization for updated EMG/NCV 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:

Updated EMG/NCV of the Bilateral Upper Extremities: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 269.

Decision rationale: According to MTUS guidelines (MTUS page 303 from ACOEM guidelines), Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. EMG has excellent ability to identify abnormalities related to disc protrusion (MTUS page 304 from ACOEM guidelines). According to MTUS guidelines, needle EMG study helps identify subtle neurological focal dysfunction in patients with neck and arm symptoms. 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 (page 178). EMG is indicated to clarify nerve dysfunction in case of suspected disc herniation (page 182). EMG is useful to identify physiological insult and anatomical defect in case of neck pain and back pain (page 179). The patient underwent nerve conduction study and EMG/NCV on July of 2013 which demonstrated the left carpal tunnel syndrome. Since that time, there is no clear documentation of clinical change in the patient's condition that supports another EMG/NCV testing. The referring physician should provide clinical information that the patient developed after her last EMG/NCV and that support the diagnosis of radiculopathy. Therefore, the request for updated EMG/NCV of the bilateral upper extremities is not medically necessary.