

Case Number:	CM14-0201242		
Date Assigned:	12/11/2014	Date of Injury:	04/07/2014
Decision Date:	01/28/2015	UR Denial Date:	11/07/2014
Priority:	Standard	Application Received:	12/01/2014

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 Family Practice 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:

The patient is a 50 year-old woman who was injured at work on 4/7/2014. The injury was primarily to her back, neck and left wrist. She is requesting review of denial for the following: EMG Left Lower Extremity; NCV Right Lower Extremity; NCV Left Lower Extremity; and EMG Right Lower Extremity. Medical records corroborate ongoing care for her injuries. These records include the Primary Treating Physician's Progress Reports. The chronic diagnoses in these records include: Left Wrist Tenosynovitis; Cervical Strain; Thoracic Strain; and Lumbar Strain. A request for authorization was submitted on 7/7/2014 for the stated EMG and NCV studies of the upper and lower extremities. Documentation in the medical records includes a progress note from 6/19/2014. Physical examination at this visit was notable for symmetric 4/5 strength and intact sensation. Deep tendon reflexes were documented to be normal (3+ and symmetric). An office visit on 10/13/2014 includes a physical exam with similar findings; intact strength, sensation, and deep tendon reflexes. In the Utilization Review process MTUS/ACOEM guidelines were cited in the assessment of the request for EMGs and NCVs. The reviewer's comments stated the following: "the medical information submitted for review did not indicate specific clinical symptoms or objective findings suggestive of lumbar spine radiculopathy or peripheral neuropathy of the lower extremities to warrant both nerve conduction and needle EMG studies."

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG left lower extremity: 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): 165-170. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chronic, Electrodiagnostic Testing.

Decision rationale: The MTUS/ACOEM Guidelines provide specific comment on the indications for electrodiagnostic testing. In general, "the neurologic examination should focus on a few tests that reveal evidence of nerve root impairment, peripheral neuropathy, or spinal cord dysfunction (page 170). The guidelines state that this examination should include: Testing for muscle strength, circumferential measurements assessing for muscle atrophy, deep tendon reflexes, and assessment of sensory function. Diagnostic criteria (Table 8-4) should demonstrate evidence of a specific sensory, motor or reflex change that suggests nerve impingement. The Official Disability Guidelines (ODG), (Chronic Pain) comment on the use of electrodiagnostic testing. These guidelines state the following: Electromyography (EMG) and Nerve Conduction Studies (NCS) are generally accepted, well-established and widely used for localizing the source of the neurological symptoms and establishing the diagnosis of focal nerve entrapments, such as carpal tunnel syndrome or radiculopathy, which may contribute to or coexist with CRPS II (causalgia), when testing is performed by appropriately trained neurologists or physical medicine and rehabilitation physicians. EMG and NCS are separate studies and should not necessarily be done together. In the Carpal Tunnel Syndrome Chapter it says that NCS is recommended in patients with clinical signs of CTS who may be candidates for surgery, but EMG is not generally necessary. In the Low Back Chapter and Neck Chapter, it says NCS is not recommended, but EMG is recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. Electrodiagnostic studies should be performed by appropriately trained Physical Medicine and Rehabilitation or Neurology physicians. Minimum Standards for electrodiagnostic studies: The American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) recommends the following minimum standards: (1) EDX testing should be medically indicated. (2) Testing should be performed using EDX equipment that provides assessment of all parameters of the recorded signals. Studies performed with devices designed only for "screening purposes" rather than diagnosis is not acceptable. (3) The number of tests performed should be the minimum needed to establish an accurate diagnosis. (4) NCSs (Nerve conduction studies) should be either (a) performed directly by a physician or (b) performed by a trained individual under the direct supervision of a physician. Direct supervision means that the physician is in close physical proximity to the EDX laboratory while testing is underway, is immediately available to provide the trained individual with assistance and direction, and is responsible for selecting the appropriate NCSs to be performed. (5) EMGs (Electromyography - needle not surface) must be performed by a physician specially trained in electrodiagnostic medicine, as these tests are simultaneously performed and interpreted. (6) It is appropriate for only 1 attending physician to perform or supervise all of the components of the electrodiagnostic testing (e.g., history taking, physical evaluation, supervision and/or performance of the electrodiagnostic test, and interpretation) for a given patient and for all the testing to occur on the same date of service. The reporting of NCS and EMG study results should be integrated into a

unifying diagnostic impression. (7) In contrast, dissociation of NCS and EMG results into separate reports is inappropriate unless specifically explained by the physician. Performance and/or interpretation of NCSs separately from that of the needle EMG component of the test should clearly be the exception (e.g. when testing an acute nerve injury) rather than an established practice pattern for a given practitioner. In this case, there is insufficient rationale provided in support of electrodiagnostic testing for this patient's symptoms. The medical information submitted for review did not indicate specific clinical symptoms or objective findings suggestive of lumbar spine radiculopathy or peripheral neuropathy of the lower extremities to warrant both nerve conduction and needle EMG studies. Physical examination findings documented above indicated normal strength, sensation and deep tendon reflexes. In summary, there is no information provided that supports a specific sensory, motor or reflex change that suggests nerve impingement. Therefore, this request is not medically necessary.

NCV right lower extremity: 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): 165-170. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain, Electrodiagnostic Testing.

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