

<b>Case Number:</b>	CM15-0001921		
<b>Date Assigned:</b>	01/12/2015	<b>Date of Injury:</b>	01/17/2014
<b>Decision Date:</b>	07/02/2015	<b>UR Denial Date:</b>	12/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/05/2015

### 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:

The injured worker is a 40 year old male, who sustained an industrial injury on January 17, 2014. The injured worker was diagnosed as having cervical disc protrusion, cervical muscle spasm, cervical sprain/strain, thoracic sprain/strain, lumbar sprain/strain, anxiety, and depression. Treatment to date has included physical therapy, Functional Capacity Evaluation (FCE), MRIs, acupuncture, ultrasound, and medication. Currently, the injured worker complains of neck pain, stiffness, and heaviness, upper/mid back pain and stiffness, constant severe low back pain and stiffness, and depression and anxiety. The Primary Treating Physician's report dated October 25, 2014, noted the injured worker reported his neck pain as 6/10 and low back pain as 7/10, with both areas better with medication. Physical examination was noted to show tenderness to palpation and muscle spasms of the bilateral trapezil and cervical paravertebral muscles. Tenderness to palpation was noted in the thoracic and lumbar paravertebral muscles. The treatment plan was noted to include acupuncture for the cervical, thoracic, and lumbar spine, a cervical traction system, chiropractic treatments for the cervical spine, thoracic spine, and lumbar spine, a cold/heat therapy unit, a lumbar brace, electromyography (EMG)/nerve conduction velocity (NCV), physical therapy for the cervical, thoracic, and lumbar spine, Return to Work (RTW)/Functional Capacity Evaluation (FCE) evaluation, toxicology testing, and Voltage-Actuated Sensory Nerve Conduction (VSNCT) examination.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**NCV/EMG lumbar, thoracic and cervical spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 174, 303.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173.

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