MAXIMUS Federal Services

Case Number:	CM15-0002968		
Date Assigned:	01/13/2015	Date of Injury:	11/19/2001
Decision Date:	03/10/2015	UR Denial Date:	12/08/2014
Priority:	Standard	Application Received:	01/07/2015

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: California, Indiana, New York
Certification(s)/Specialty: Internal Medicine

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 57 year old woman sustained an industrial injury on 11/19/2001. The mechanism of injury is not detailed. Current diagnoses include musculoligamentous sprain/strain of the cervical spine with severe spinal stenosis with cord compression, severe neuropathic pain, bilateral carpal tunnel syndrome, and mild bilateral ulnar neuropathy at the elbow. Evaluations include an MRI of the cervical spine dated 11/11/2014 showed moderate to severe stenosis, EMG/NCV dated 12/6/2012 showed radiculopathy, bilateral carpal tunnel syndrome, and cubital tunnel syndrome, x-rays of the cervical spine dated 2/28/2013 showed degenerative changes and neural foraminal narrowing. Treatment has included oral medications, and surgical intervention. Neurology notes dated 11/20/2014 show complaints of pain with numbness and tingling down both arms with constant migraines. Another physician has requested a new EMG and nerve conduction velocity. The possibility of further surgical intervention was discussed. On 12/8/2014, Utilization Review evaluated a prescription for electromyeography/nerve conduction velocity of the upper extremities, which was submitted on 1/5/2015. The UR physician noted that there is minimal justifiction for performing nerve conduction studies when radiculopathty is present. The MTUS, ACOEM Guidelines, (or ODG) was cited. The request was denied and subsequently appealed to Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electromyography (EMG) /Nerve Conduction Velocity (NCV) of the upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 10 Elbow Disorders (Revised 2007), Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): Table 8-8 Summary of Recommendation for Evaluating and Manging Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter: Neck & Upper Back (Acute & Chronic) Electromyography (EMG); Nerve Conduction Studies

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Neck section, EMG/NCV

Decision rationale: Pursuant to the Official Disability Guidelines, EMG/NCV of the bilateral upper extremities is not medically necessary. Nerve conduction studies are not recommended to demonstrate radiculopathy if radiculopathy has already been identified by EMG and obvious clinical signs, but recommended if the EMG is not clearly radiculopathy for clearly negative or to differentiate radiculopathy from other neuropathies for non-neuropathic processes that may be likely based on clinical examination. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy. While cervical electrodiagnostic studies are not necessary to demonstrate a cervical radiculopathy, they have been suggested to confirm brachial plexus abnormality, diabetic neuropathy or some other cervical radiculopathy, with caution that these studies can result in unnecessary over treatment. In this case, the injured worker's working diagnoses are cervical DJD at C3-C4, C4-C5, and C5-C6; chronic headaches; and C5-C6 radiculopathy. The treating physician prescribed and the injured worker underwent an EMG/NCV of the bilateral upper extremities December 6, 2012. The results included subacute-chronic C5-C6 radiculopathy bilaterally. 2) Mild chronic C7-C8 radiculopathy bilaterally. 3) Mild bilateral CTS. 4) Mild left cubital tunnel syndrome. Subjectively, the injured worker complains of significant neck pain radiating to the left arm down to the fingers. Symptoms spread into the face. She has increased weakness in the left hand and drops light objects frequently. Objectively, the temporalities muscles are tender bilaterally and there is scalp allodynia. Motor examination is 4/5 in the bilateral upper extremities with decreased light touch and pinprick in the distribution of the left C6 - C8 distribution. The guidelines state: "There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy". The documentation does not indicate whether the symptoms and signs involving the upper extremities with radiculopathy have improved, remain the same or worsened. MRI cervical spine November 11, 2014 shows mild stenosis at C5 - C6 with no foraminal stenosis. There is generalized congenital stenosis of the entire cervical spine series at C3 - C5 uncinate spurring with moderate stenosis is noted. The plan indicates EMG/NCV's bilateral upper extremities were ordered to identify the surgical targets. Medical records do not contain documentation of anticipated surgery and, as noted above, there are no clinical changes in the bilateral upper extremity's radicular symptomatology. Consequently, absent clinical documentation showing a change in the upper extremity radicular signs and symptoms having had a prior EMG/NCV, EMG/NCV of the bilateral upper extremities is not medically necessary.