

<b>Case Number:</b>	CM15-0113363		
<b>Date Assigned:</b>	06/19/2015	<b>Date of Injury:</b>	06/26/2010
<b>Decision Date:</b>	07/24/2015	<b>UR Denial Date:</b>	06/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/11/2015

### 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: Montana

Certification(s)/Specialty: Preventive Medicine, Occupational 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:

The injured worker is a 55 year old male, who sustained an industrial injury on 6/26/10. He has reported initial complaints of a neck injury. The diagnoses have included left cervical radiculopathy and ongoing low back radiculopathy. Treatment to date has included medications, activity modifications, diagnostics, acupuncture and epidural steroid injection (ESI). Currently, as per the physician progress note dated 4/28/15, the injured worker complains of sudden, intense pain in the neck that radiates to both arms with headaches. The pain goes to the mid back, both arms and fingers. There is also numbness and tingling in both arms. The pain is aggravated by almost any activity. The physical exam reveals positive axial compression and radiating into the C6 distribution of the left arm. The injured worker also complains of radiating pain into the right arm. There is tenderness in the left neck with muscle tightness and rigidity noted. The cervical spine range of motion was 5 percent lateral bending to the left, 15 percent to the right, rotation to the left was 15 percent , to the right 30 percent, upward gazing was 0 percent and forward flexion in the cervical spine to 30 percent. There is decreased sensation in the C6-C7 distribution on the left. There was decreased sensation in the right arm, non-dermatomal. The flexions were decreased in the brachioradialis on the left. The exam of the back and lower extremities had continued tenderness with limited range of motion of the low back and left buttocks. The physician noted that the cervical spine Magnetic Resonance Imaging (MRI) dated 8/2/10 showed mild degenerative bulging of the C3-4 disc with spurring. There was protrusion and possibility of compression or impression upon the left C6 root sleeve. Correlate clinically for left C6 radiculopathy. There are mild degenerative changes at C6-7. However, there are no hard copy diagnostic studies or cervical Magnetic Resonance Imaging (MRI) noted in the records. The physician requested treatment included Bilateral Upper Extremity

Electromyography/Nerve Conduction Velocity.

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

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

**Bilateral Upper Extremity Electromyography/Nerve Conduction Velocity:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178 and 182. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Electromyography and Nerve conduction studies.

**Decision rationale:** The MTUS states that electromyography (EMG) is recommended to clarify nerve root dysfunction in cases of suspected disc herniation preoperatively or before epidural injection. The ODG states that while cervical electrodiagnostic studies are not necessary to demonstrate a cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality or some problem other than a cervical radiculopathy, but these studies can result in unnecessary over treatment. Electrodiagnostic studies should be performed by appropriately trained Physical Medicine and Rehabilitation or Neurology physicians. 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. The MTUS states that 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 3 or 4 weeks. The ODG states that nerve conduction studies (NCS, used interchangeably with nerve conduction velocities (NCV)) are not recommended to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but recommended if the EMG is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely based on the clinical exam. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy. Electrodiagnostic studies should be performed by appropriately trained Physical Medicine and Rehabilitation or Neurology physicians. 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, the treating physician has clearly noted radicular complaints in a dermatomal pattern with a diagnosis of cervical radiculopathy. As noted above, there is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy. There is no documentation of other potential diagnoses for which electrodiagnostic testing would be

appropriate. The request for Bilateral Upper Extremity Electromyography/Nerve Conduction Velocity is not medically necessary.