Case Number:	CM15-0120887		
Date Assigned:	07/01/2015	**Date of Injury:**	06/29/2009
Decision Date:	07/30/2015	**UR Denial Date:**	06/02/2015
Priority:	Standard	**Application Received:**	06/23/2015

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: New Jersey, Alabama, California
Certification(s)/Specialty: Neurology, Neuromuscular 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 46-year-old male, who sustained an industrial injury on June 29, 2009. He reported an injury to his neck and back. Treatment to date has included MRI of the cervical spine, anterior cervical microdiscectomy and interbody arthrodesis, chiropractic therapy, home exercise program, work restrictions and medications. Currently, the injured worker complains of increased numbness and tingling of the hands. On physical examination, the injured worker has limited cervical spine range of motion. He has no motor weakness or sensory loss in the bilateral upper extremities. He has no tenderness to palpation or spasm of the cervical spine and the paracervical musculature. He has a trigger finger of the left middle finger. The evaluating physician advised the injured worker that the left middle finger triggering is not related to his industrial injury. The diagnoses associated with the request include status post redo anterior cervical microdiscectomy and interbody arthrodesis at C5-6 and C6-7 and probable trigger finger of the left hand. The treatment plan includes MRI of the lumbar spine and electrodiagnostic testing of the bilateral upper extremities and bilateral lower extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV of bilateral lower extremities- back: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

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. (Page 179) In this case, the patient previous EMG/NCV performed on 2013 was negative for radiculopathy or neuropathy. There is no documentation of significant change in symptoms and/or new findings suggestive of a new pathology. Therefore, the request for EMG/NCV of bilateral lower extremities- back is not medically necessary.

EMG/NCS of bilateral upper extremities- neck: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

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. (Page 179) There is no documentation of peripheral nerve damage, cervical radiculopathy and entrapment neuropathy that requires electro diagnostic testing. There is no documentation of significant change in the patient condition. Therefore, the request for EMG/NCS of bilateral upper extremities- neck is not medically necessary.