

<b>Case Number:</b>	CM15-0164826		
<b>Date Assigned:</b>	09/10/2015	<b>Date of Injury:</b>	05/06/2009
<b>Decision Date:</b>	11/10/2015	<b>UR Denial Date:</b>	07/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/21/2015

### 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: Arizona, California

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 55 year old male, who sustained an industrial injury on 5-6-09. The documentation on 7-9-15 noted that the injured worker has complaints of progressive limited range of motion to the neck associated with severe muscle spasms. The pain is described as level 8 out of 10 most of the time with flare ups reaching level 9 out of 10 toward the end of the day or with any moderate activity. The injured worker states pain is worse at nighttime and causes his difficulty in falling asleep and maintaining sleep without the aid of sleeping pills. The injured worker has moderate to severe lower back pain associated with severe muscle spasm and progressive limits range of motion to the lumbar spine. The injured worker describes the pain as level 8 out of 10 most of the time with flare-ups reaching level 9 out of 10. The documentation noted that he injured worker reports experiencing pain over the right buttock region, radiating to the posterior and lateral aspects of the right thigh with numbness and tingling progressively increasing in severity. The documentation noted that the injured worker is suffering from multiple cervical and lumbar disc herniation with signs and symptoms of radiculitis and radiculopathy of the upper and lower extremities. The injured worker is also suffering from severe sacroiliac joint inflammation with signs and symptoms of radiculitis and radiculopathy to the posterior and lateral aspect of the thigh. The Gaenslen's test and Patrick Fabre test were positive and the sacroiliac joint thrust demonstrated as severely positive 7-9-15 exam. There is pain on palpation over the spinous processes from C3-C6 and there is increased tone in the right and left trapezius with point tenderness in the form of severe myofascial pain on deep palpation with severe guarding. The cervical compression test is positive and the cervical distraction test is

positive. Range of motion for lumbar and cervical on forward flexion, extension, right lateral flexion, left lateral flexion, right rotation and left rotation were decreased. Straight leg raising tests are severely positive in both the seated and supine positions. The diagnoses have included cervical sprain and strain; cervical paraspinal muscle spasms; cervical disc herniation; cervical radiculitis and radiculopathy; lumbar sprain and strain; lumbar paraspinal muscle spasms and lumbar disc herniations. Magnetic resonance imaging (MRI) of the lumbar spine on 6-25-09 showed 5 millimeter posterior disc bulges at both L4-5 and L5-S1 (sacroiliac) with mild central canal narrowing at both levels and an annular fissure in the posterior aspect of the L4-5 disc; bilateral facet hypertrophy which is mild to moderate at L4-5 and moderate to severe at L5-S1 (sacroiliac); neural foraminal narrowing which is bilaterally mild to moderate at L4-L5 and at L5-S1 (sacroiliac) mild to moderate on the left and mild on the right and benign appearing L4 intraosseous lesion. Treatment to date has included lumbar disc fusion and hardware placement; physical therapy with limited improvement; acupuncture with limited improvement; chiropractic treatment; home exercise program; pain medications; anti-inflammatory medications; muscle relaxants and sleeping pills. The original utilization review (7-21-15) denied the request for electromyography and nerve conduction study of bilateral upper extremity cervical spine for not being medically necessary. Several documents within the submitted medical records are difficult to decipher.

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

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

**EMG/ Nerve Conduction Study of BUE Cervical Spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies, Summary, and Forearm, Wrist, and Hand Complaints 2004, Section(s): Special Studies, Summary.

**Decision rationale:** According to the guidelines, EMG/NCV is recommended for ulnar impingement after failure of conservative treatment. It is not recommended for routine evaluation of nerve entrapment without symptoms. According to the guidelines, an EMG is recommended to clarify nerve root dysfunction in cases of suspected disk herniation preoperatively or before epidural injection. It is not recommended for the diagnoses of nerve root involvement if history and physical exam, and imaging are consistent. An NCV is 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. In this case, the exam findings show radiculopathy. Although an EMG can be used to clarify radiculopathy, the request for an epidural for the cervical spine preceded the EMG/NCV requests. In addition, the EMG results are not known to determine if there are abnormalities requiring an NCV. As a result, the combined tests requested above are not medically necessary.