

Case Number:	CM15-0171570		
Date Assigned:	09/14/2015	Date of Injury:	04/29/2015
Decision Date:	10/13/2015	UR Denial Date:	08/26/2015
Priority:	Standard	Application Received:	09/01/2015

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 50-year-old male, who sustained an industrial injury on April 29, 2015, incurring head, neck and back injuries. Computed tomography of the brain revealed no acute intracranial pathology, and a right frontoparietal scalp hematoma. On April 29, 2015, Magnetic Resonance Imaging of the cervical spine showed a nondisplaced fracture. He was diagnosed with a cervical transverse fracture, acute head trauma, chronic brain injury, cervical and lumbar disc displacement and a complex scalp laceration. Treatment included immobilization of the cervical spine, Electromyography studies to rule out neuropathy, acupuncture, anti-inflammatory drugs, pain medications, sleep aides, neurosurgery and ophthalmologist consultations. On August 15, 2015, the injured worker was evaluated for pain management. He complained of constant neck and head pain associated with headaches. He noted decreased cervical range of motion. He had intermittent dull sharp pain all the time. He noted diffuse pain all over the body included upper and lower extremities. He denied weakness of the extremities, bladder or bowel dysfunction. The treatment plan that was requested for authorization September 1, 2015, included Electromyography studies of the bilateral upper extremities. On August 26, 2015, utilization review the request for Electromyography studies was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electromyogram (EMG)/Nerve conduction velocity of the bilateral upper extremities:
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.

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