MAXIMUS Federal Services

Case Number:	CM15-0179921		
Date Assigned:	09/21/2015	Date of Injury:	09/19/2014
Decision Date:	10/26/2015	UR Denial Date:	08/14/2015
Priority:	Standard	Application Received:	09/11/2015

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: Massachusetts
Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 39 year old male, who sustained an industrial-work injury on 9-19-14. A review of the medical records indicates that the injured worker is undergoing treatment for cervical disc degeneration and pain in the joint involving the shoulder. Medical records dated (2-13-15 to 7-13-15) indicate that the injured worker complains that parts of his injury have worsened. He has been having trouble with sleeping and complaining of neck hurting worse, pain in medial right elbow with full extension and right and left arm pain, numbness, tingling and weakness that awakens him in the morning with associated headaches. The pain rating on the medical record dated 7-13 15 is rated 8 out of 10 on pain scale. The medical records also indicate worsening of the activities of daily living. Per the treating physician report dated 4-15- 15 the injured worker has not returned to work. The right upper extremity exam shows weakness of the hand grips and there is loss of sensation in C5 and C6 dermatome. There is weakness and atrophy of the right upper arm, there is pain with range of motion of the right elbow and the right handgrip is 1 out of 5 related to the thumb, index and long finger. The physical exam dated 7-13-15 reveals that the injured worker appears to be in moderate pain with right arm flexed and held against the torso and abdomen. The cervical spine is noted to be in a brace. Treatment to date has included pain medication, diagnostics, and cervical fusion 4-30-15, physical therapy at least 18 sessions, consultations and other modalities. The computerized axial tomography (CT scan) of the cervical spine dated 1-28-15 reveals a posterior disc protrusion at C5-6 and a broad based posterior disc protrusion at C6-7. The disc protrusions contain calcifications and the overall appearance is similar to the previous study. There is solid intervertebral fusion at C4-5

which is unchanged. The myelogram of the cervical spine dated 1-28-15 reveals anterior defect at C6-7 as well as some nerve root defect. There are minimal defects noted bilaterally at C5-6 as well. The electromyography (EMG) and nerve conduction velocity studies (NCV) dated 11-26-14 of the bilateral upper extremities reveals acute right C7 radiculopathy and mild right median neuropathy at the wrist, consistent with carpel tunnel syndrome. Magnetic Resonance Imaging (MRI) of the cervical spine dated 10-8-14 reveals posterior disc bulge at C5-6 and C6-7 result in central spinal stenosis reducing the canal to 8 millimeters at both levels. There is ossification of the posterior longitudinal ligament between C5 and C7 and uncovertebral spondylosis contributes to stenosis of the neural foramina between C4-5 and C6-7. Interbody fusion has occurred at C4-5. The request for authorization date was 8-7-15 and requested service included Bilateral upper extremity electromyography (EMG) nerve conduction velocity studies (NCV). The original Utilization review dated 8-14-15 modified the request to right upper extremity electromyography (EMG) nerve conduction velocity studies (NCV) only as there is no rationale provided as to why the asymptomatic left upper extremity should be tested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral upper extremity EMG/NCV: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, and Forearm, Wrist, and Hand Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Electrodiagnostic studies (EMG), Nerve conduction studies (NCS).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (1) Pain (Chronic), Electrodiagnostic testing (EMG/NCS) (2) Carpal Tunnel Syndrome (Acute & Chronic): Electrodiagnostic studies (EDS) and Other Medical Treatment Guidelines AANEM Recommended Policy for Electrodiagnostic Medicine.

Decision rationale: The claimant sustained a work injury in September 2014 and underwent an anterior cervical decompression infusion on 04/30/15. When seen on 08/05/15 he had completed physical therapy treatments. He was having neck pain and difficulty sleeping. He had numbness and tingling in a C6 distribution and was having difficulty flexing the first finger of his right hand. There were no direct physical examination findings recorded. Authorization for repeat electrodiagnostic studies was requested. The claimant had electrodiagnostic testing done on 11/26/14 with findings of mild right carpal tunnel syndrome and an acute right C7 radiculopathy. Indications for repeat electrodiagnostic testing include the following: (1) The development of a new set of symptoms; (2) When a serious diagnosis is suspected and the results of prior testing were insufficient to be conclusive; (3) When there is a rapidly evolving disease where initial testing may not show any abnormality (e.g., Guillain-Barr syndrome); (4) To follow the course of certain treatable diseases such as polymyositis or myasthenia gravis; (5) When there is an unexpected course or change in course of a disease and; (6) To monitor recovery and help establish prognosis and/or to determine the need for and timing of surgical interventions in the setting of recovery from nerve injury. In this case, the claimant has already

had EMG/NCS testing and none of the above indications is present. Prior testing showed findings of right carpal tunnel syndrome and a right C7 radiculopathy. When requested, there was no physical examination recorded. If there had been findings that were inconsistent with the results of the prior testing done in November 2014, then testing of the right upper extremity might have been appropriate. However, there would be no need to test the asymptomatic left upper extremity. The repeat testing requested was not medically necessary.