

Case Number:	CM15-0179923		
Date Assigned:	09/21/2015	Date of Injury:	08/04/2010
Decision Date:	10/27/2015	UR Denial Date:	09/03/2015
Priority:	Standard	Application Received:	09/14/2015

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: California, South Carolina

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, 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 43 year old female who sustained an industrial injury August 4, 2010. Past history included right carpal tunnel release 2011. Past treatment included tried and failed gabapentin and Cymbalta due to side effects, physical therapy, psychiatrist-psychologist therapy, and cervical epidural steroid injection March 19, 2014) with 60-70% relief lasting 6-7 weeks. An MRI of the cervical spine dated June 23, 2015, (report present in the medical record) impression is: no significant change compared to examination dated 10-22-2014; documented as reversal of the normal cervical lordotic curve with mild disc protrusions and uncovertebral hypertrophic changes, but no evidence of central canal nor significant foraminal stenosis. A July 20, 2015 office visit, the secondary treating physician documented a cervical MRI dated October 22, 2014 shows two herniated discs at C5-6 and C6-7. According to a primary treating physician's report dated August 20, 2015, the injured worker presented with complaints of some increased numbness and tingling in the ring and small fingers bilaterally. Objective findings included: decreased range of motion of the cervical spine with some pain, slight trapezial and paracervical tenderness on the right, Spurling's test is equivocal on the right; slight volar forearm tenderness bilaterally; Tinel's sign and elbow flexion are positive at the cubital tunnels bilaterally; mild lateral epicondyle tenderness on the right; Tinel's and Phalen's test are negative at the carpal tunnels. Diagnoses are cervical radiculopathy; trapezial and paracervical strain; bilateral forearm tendinitis; right lateral epicondylitis; possible bilateral cubital tunnel syndrome; status post carpal tunnel release with ulnar nerve decompression at the wrist. Treatment included ongoing pain management, updated electrodiagnostic studies, psychological

evaluation, and continued medication. At issue is the request for authorization for repeat EMG (electromyogram) - NCS (nerve conduction studies) BUE (bilateral upper extremities). According to Utilization Review dated September 3, 2015, the request for repeat EMG-NCS of the BUE had been modified to partial certification of the NCS of BUE for evaluation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Repeat EMG of Bilateral Upper Extremities: Overturned

Claims Administrator guideline: Decision based on MTUS Elbow Complaints 2007, Section(s): Ulnar Nerve Entrapment.

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, Diagnostic Criteria. Decision based on Non-MTUS Citation ODG Neck and Upper Back (Acute & Chronic), Electromyography (EMG) ODG Neck and Upper Back (Acute & Chronic), Nerve conduction studies (NCS) and Other Medical Treatment Guidelines Aetna, Nerve Conduction Studies
http://www.aetna.com/cpb/medical/data/500_599/0502.html.

Decision rationale: Per the cited CA MTUS, electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in those with neck and/or arm symptoms, lasting more than three or four weeks. They further state that EMG may be recommended to clarify nerve root dysfunction preoperatively or before epidural injection; however, it is not recommended for nerve root diagnosis when history, exam, and imaging studies are consistent. They further state appropriate electrodiagnostic studies (EDS) may help differentiate between carpal tunnel syndrome (CTS) and other conditions, such as cervical radiculopathy. NCV for medial or ulnar impingement at the wrist after failure of conservative management may be recommended, but routine use is not recommended in injured workers without symptoms. The ODG further clarifies by recommending EMG as an option for cervical radiculopathy in selected cases; however, NCS is not recommended to demonstrate cervical radiculopathy if it has already been clearly identified by EMG and obvious clinical signs. Aetna guidelines add that NCS are recommended for localization of focal neuropathies or compressive lesions (e.g., carpal tunnel syndrome, tarsal tunnel syndrome, nerve root compression, neuritis, motor neuropathy, mononeuropathy, radiculopathy, plexopathy); and injured worker has had a needle (EMG) study to evaluate the condition either concurrently or within the past year. Looking over this injured workers case, it is relatively complex with a long-term history of cervical radicular symptoms and CTS with release. She has had persistent documented upper extremity neurologic deficits, right greater than left, and in the most recent treating provider notes September 2, 2015, she noted persistent neck, mid-low back, shoulder, and right upper extremity pain with numbness in right/left fingertips. Overall, the injured workers symptoms appear progressive, and although the previous BUE EMG/NCS was not available, Utilization Review stated it was normal in October 2011. In review of the available medical records and cited guidelines, it would be reasonable to reassess the injured worker for focal neurologic dysfunction that is amenable to surgical intervention. Therefore, the request for repeat EMG of bilateral upper extremities is medically necessary and appropriate since the injured worker is authorized for NCS of the same.