

Case Number:	CM15-0065773		
Date Assigned:	04/13/2015	Date of Injury:	06/12/2009
Decision Date:	05/27/2015	UR Denial Date:	03/16/2015
Priority:	Standard	Application Received:	04/07/2015

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, Texas
 Certification(s)/Specialty: Internal 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 female, who sustained an industrial injury on 6/12/09. She reported initial complaints of cervical and lumbar spine. The injured worker was diagnosed as having brachial neuritis/radiculitis NOS; arthropathy unspecified; lumbosacral spondylosis without myelopathy; intervertebral disc disorder with myelopathy lumbar region; intervertebral disc disorder with myelopathy cervical region. Treatment to date has included physical therapy; acupuncture; Cervical and lumbar spine x-rays (3/5/15); medications. Currently, the PR-2 notes dated 3/5/15 indicates the injured worker complains of neck and low back pain and aggravated by prolonged sitting and standing and alleviated by lying down. The neck pain radiates into the right arm and both are equal in pain levels with associated numbness, tingling and weakness. She reports she gets intermittent muscle cramps in her legs and describes the pain as constant sharp and 10/10 for pain levels. Currently she is taking prescribed pain medications: Lyrica 75mg daily, Naproxen 550mg daily, Norco 10/325mg twice daily and Xanax twice daily. The provider's examination notes cervical and lumbar range of motion both at 50% of normal with a decreased sensation in the right C8 distribution; notes injured worker experiences pain with grip strength testing. Radiographic studies 3/5/15 were reviewed and show evidence of severe degenerative disease at C6-7 with moderate changes at C5-6. Lumbar spine x-rays on this date show evidence of mild degenerative disc disease with moderate left-sided facet arthrosis L3-4 and L4-5. The provider is requesting an EMG of the right upper extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG RIGHT UPPER EXTREMITIES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

Decision rationale: Nerve conduction study (NCS) techniques permit stimulation and recording of electrical activity from individual peripheral nerves with sufficient accuracy, reproducibility, and standardization to determine normal values, characterize abnormal findings, and correlate neurophysiologic-pathologic features. These clinical studies are used to diagnose focal and generalized disorders of peripheral nerves, aid in the differentiation of primary nerve and muscle disorders (although NCS itself evaluates nerve and not muscle), classify peripheral nerve conduction abnormalities due to axonal degeneration, demyelination, and conduction block and prognosticate regarding clinical course and efficacy of treatment. NCS should not be performed or interpreted as an isolated diagnostic study. Instead, it should be performed and interpreted at the same time as an EMG. When definitive neurologic findings on physical exam, electrodiagnostic studies, lab tests, or bone scans are present imaging may be warranted. 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), may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. In this case the patient has had previous EMG suggesting a radiculopathy. The physical exam also confirms neurological deficit with sensory deficits in C8 level. The documentation doesn't suggest that the patient has had progression of neurological dysfunction. A repeat EMG of the right upper extremity is not medically necessary.