

<b>Case Number:</b>	CM15-0067061		
<b>Date Assigned:</b>	04/14/2015	<b>Date of Injury:</b>	02/08/2006
<b>Decision Date:</b>	05/13/2015	<b>UR Denial Date:</b>	03/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/08/2015

### 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 51-year-old male injured worker suffered an industrial injury on 02/08/2006. The diagnoses included post-operative cervical fusion, cervical and lumbar spine herniated nucleus pulposus with radiculopathy, right carpal tunnel syndrome, and bilateral plantar fasciitis. The diagnostics included electromyographic studies/nerve conduction velocity studies upper and lower extremities 2006 and cervical/lumbar magnetic resonance imaging 2009. The injured worker had been treated with physical therapy, left shoulder injections, cervical fusion and right shoulder arthroscopy. On 1/6/2015, the treating provider reported constant cervical spine pain with associated headaches along with decreased sensations over the forehead and the pain radiated to the hands with numbness and tingling. There is right wrist and hand pain with numbness and tingling, right shoulder pain, constant low back pain that radiated to the thighs with numbness and tingling, bilateral plantar pain and right elbow pain. The treatment plan included Electromyography (EMG)/Nerve conduction velocity (NCV) of the bilateral upper extremities.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Electromyography (EMG)/Nerve conduction velocity (NCV) of the bilateral upper extremities:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, Cervical & thoracic spine, 2013.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173-174.

**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 or subtle physiologic evidence of tissue insult or neurologic dysfunction bilaterally. There is no mention of planned invasive procedures. There are no subtle neurologic findings listed on the physical exam bilaterally. For these reasons criteria for special diagnostic testing has not been met per the ACOEM for bilateral EMG/NCV. Therefore, the request is not medically necessary.