

Case Number:	CM15-0068429		
Date Assigned:	04/16/2015	Date of Injury:	12/04/2013
Decision Date:	05/19/2015	UR Denial Date:	03/25/2015
Priority:	Standard	Application Received:	04/10/2015

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

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 42 year old male, who sustained an industrial injury on December 4, 2013. He reported experiencing pain in his neck, right shoulder, and lower back from the physical demands of working as a bartender. The injured worker was diagnosed as having multilevel cervical spondylosis with radicular symptomology bilateral upper extremities, and degenerative disc disease with associated facet arthropathy at L4- L5, L5-S1, and lesser at L3-L4 with radicular symptomology of the lower extremities. Treatment to date has included physical therapy, chiropractic treatments, subacromial right shoulder injection, trigger point injections, MRIs, and medication. Currently, the injured worker complains of constant moderately severe pain of the cervical spine, headaches, pain of the superior aspect of the trapezius muscles in the shoulders, occasional radiation of pain to the upper extremities with numbness, tingling, and weakness of both upper extremities, and constant moderately severe pain of the lumbosacral spine, occasional radiation of pain to both lower extremities with generalized weakness, numbness, and paresthasias. The Initial Comprehensive Spine Evaluation dated March 13, 2015, noted spinous process tenderness throughout the cervical spine with moderate paraspinal muscle guarding and tenderness, occipital tenderness, and moderate bilateral trapezius spasm and tenderness, slightly greater on the left than on the right. The injured worker was noted to have generalized weakness of both upper extremities, appearing generally weaker on the right side. The Physician noted the injured worker was not improving and additional diagnostic testing was necessary with a recommendation for an electromyography (EMG)/nerve conduction velocity

(NCV) of the upper and lower extremities along with MRIs of the lumbar spine and cervical spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

NCV bilateral upper extremity: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 177-178, 260-262.

Decision rationale: Based on the 03/13/15 progress report provided by treating physician, the patient presents with neck pain with radiation to upper extremities with numbness, tingling and paresthesias. The request is for NCV bilateral upper extremity. No RFA provided. Patient's diagnosis on 03/13/15 included multilevel cervical spondylosis with radicular symptomatology bilateral upper extremities. Diagnosis on 02/18/15 included carpal tunnel syndrome and carpal tunnel syndrome. Treatment to date has included physical therapy, chiropractic treatments, subacromial right shoulder injection, trigger point injections, MRIs, and medication. Patient is to remain off work, per 02/18/15 treater report. MTUS/ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8, Neck and Upper Back Complaints, Special Studies and Diagnostic and Treatment Considerations, page 178 states: "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." ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11, page 260-262 states: "Appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful. NCS and EMG may confirm the diagnosis of CTS but may be normal in early or mild cases of CTS. If the EDS are negative, tests may be repeated later in the course of treatment if symptoms persist." UR letter dated 03/25/15 states "...there is no documentation of any subtle focal neurological dysfunction on physical examination..." Physical examination to the cervical spine on 03/13/15 revealed guarding and tenderness to palpation to the paraspinal muscles. Range of motion was decreased, especially on bilateral lateral bending 20 degrees. Generalized weakness of upper extremities on motor examination. Slightly decreased biceps, triceps and brachioradialis deep tendon reflexes. Given patient's symptoms with numbness, tingling and paresthesias to the upper extremities, the request appears reasonable and to be in accordance with guidelines. There is no evidence of prior upper extremity EMG/NCS studies done. Therefore, the request is medically necessary.

EMG bilateral upper extremity: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 177-178, 260-262.

Decision rationale: Based on the 03/13/15 progress report provided by treating physician, the patient presents with neck pain with radiation to upper extremities with numbness, tingling and paresthesias. The request is for EMG bilateral upper extremity. No RFA provided. Patient's diagnosis on 03/13/15 included multilevel cervical spondylosis with radicular symptomatology bilateral upper extremities. Diagnosis on 02/18/15 included carpal tunnel syndrome and carpal tunnel syndrome. Physical examination to the cervical spine on 03/13/15 revealed guarding and tenderness to palpation to the paraspinal muscles. Range of motion was decreased, especially on bilateral lateral bending 20 degrees. Generalized weakness of upper extremities on motor examination. Slightly decreased biceps, triceps and brachioradialis deep tendon reflexes. Treatment to date has included physical therapy, chiropractic treatments, subacromial right shoulder injection, trigger point injections, MRIs, and medication. Patient is to remain off work, per 02/18/15 treater report. MTUS/ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8, Neck and Upper Back Complaints, Special Studies and Diagnostic and Treatment Considerations, page 178 states: "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." ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11, page 260-262 states: "Appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful. NCS and EMG may confirm the diagnosis of CTS but may be normal in early or mild cases of CTS. If the EDS are negative, tests may be repeated later in the course of treatment if symptoms persist." UR letter dated 03/25/15 states "...there is no documentation of any subtle focal neurological dysfunction on physical examination..." Physical examination to the cervical spine on 03/13/15 revealed guarding and tenderness to palpation to the paraspinal muscles. Range of motion was decreased, especially on bilateral lateral bending 20 degrees. Generalized weakness of upper extremities on motor examination. Slightly decreased biceps, triceps and brachioradialis deep tendon reflexes. Given patient's symptoms with numbness, tingling and paresthesias to the upper extremities, the request appears reasonable and to be in accordance with guidelines. There is no evidence of prior upper extremity EMG/NCS studies done. Therefore, the request is medically necessary.