

Case Number:	CM15-0073838		
Date Assigned:	04/23/2015	Date of Injury:	11/05/2003
Decision Date:	05/21/2015	UR Denial Date:	04/09/2015
Priority:	Standard	Application Received:	04/17/2015

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, Indiana, New York
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 67-year-old male, who sustained an industrial injury on November 5, 2003. The injured worker was diagnosed as having cervical sprain, cervical disc degeneration, lumbar sprain, lumbar radiculitis, scoliosis, left knee sprain, left knee loose body, and tenosynovitis of the bilateral wrists and hands. Treatment to date has included lumbar epidural injection/ bilateral facet blocks, and medication. Currently, the injured worker complains of constant moderate to severe neck pain, stiffness, tightness and occasional spasm, with numbness and tingling in the arms, left greater than right, slight to moderate low back pain, with occasional stiffness and tightness, and moderate pain over the left kneecap. The Primary Treating Physician's report dated February 11, 2015, noted the injured worker was able to return to work without restrictions on February 10, 2015, however he was unable to work due to increased neck pain. The injured worker's medications were listed as Norco and Terocin cream. The physical examination was noted to show the cervical spine with a mildly positive Spurling's test on the right and loss of sensation over the right C7 nerve root distribution. The Physician noted the injured worker with ongoing cervical spine, lumbar spine, and left knee pain with the cervical complaints increased in intensity without specific cause. The injured worker was noted to have numbness and tingling in the hands with a loss of sensation over the right C7 nerve root distribution. Authorization was requested for an up-to-date MRI scan of the cervical spine, and electromyography (EMG) testing of the upper extremities for further evaluation.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV both upper and lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck Section, Low Back Section, EMG/NCV.

Decision rationale: Pursuant to the Official Disability Guidelines, EMG/NCV of the bilateral upper and lower extremities is not medically necessary. The ACOEM states (chapter 8 page 178) unequivocal finding that identifies specific nerve compromise on the neurologic examination is sufficient evidence to warrant imaging 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. Nerve conduction studies are not recommended to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but recommended if the EMG is not clearly radiculopathy or clearly negative or to differentiate radiculopathy from other neuropathies or non-neuropathies if other diagnoses may be likely based on physical examination. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms because of radiculopathy. While cervical electro diagnostic studies are not necessary to demonstrate his cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality, diabetic property or some problem other than cervical radiculopathy. Nerve conduction studies are not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms because of radiculopathy. EMGs may be useful to obtain unequivocal evidence of radiculopathy, after one-month conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious. The ACOEM states unequivocal finding that identifies specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging if symptoms persist. In this case, the injured worker's working diagnoses are cervical sprain; degeneration cervical disc; lumbar sprain; lumbar radiculitis; scoliosis; sprained left knee; loose body left knee; and tenosynovitis bilateral wrists and hands. Subjectively, according to the most recent progress note dated February 11, 2015, the injured worker complained of increasing neck pain. He denied radicular pain in the arms but did note numbness and tingling. The injured worker notes the low back pain has been feeling better and denies radicular pain, numbness or tingling in the lower extremities at this time. Objectively, the documentation indicates there is loss of sensation over the right C7 nerve root distribution. The examination included range of motion of the cervical spine. The injured worker underwent previous EMGs and EMG nerve conduction studies. On July 8, 2012, the injured worker had an EMG of the bilateral upper extremities. The results show evidence of a right C7-8 radiculopathy and findings indicative of patient having a double crush type of phenomenon. On April 2, 2014 (according to the UR), the worker was seen for symptoms/test results for right carpal tunnel syndrome, mild, and previously more severe and right ulnar neuropathy at the elbow, mild to moderate. Additionally, EMG and NCV findings on October 8, 2013 noted the right

median/ulnar palmer showed abnormal peak latency all remaining errors within normal limits. The left wrist study on October 8, 2013 was consistent with mild left carpal tunnel syndrome. The treatment plan in the February 11, 2015 progress note states the treating provider would like to update the EMG testing of the upper extremities for further evaluation. There is no clinical rationale in the medical record for updated EMG. There is no clinical indication in the medical record for an updated EMG. Prior EMG/nerve conduction studies show a right C7 - CA radiculopathy. There are no new clinical neurologic findings present on examination. There was no neurologic examination performed on February 11, 2015 except for sensory examination. Consequently, absent clinical documentation with a clinical indication and rationale for repeat EMG/nerve c onduction velocity studies with two prior EMGs, EMG/NCV of the bilateral upper and lower extremities is not medically necessary.