

<b>Case Number:</b>	CM15-0095386		
<b>Date Assigned:</b>	05/21/2015	<b>Date of Injury:</b>	07/23/2013
<b>Decision Date:</b>	06/26/2015	<b>UR Denial Date:</b>	04/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/18/2015

### 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 57 year old female who sustained an industrial injury on 04/16/2013. Mechanism of injury was related to performing routine desk and typing work. She has pain in her neck, shoulder and upper extremity. Diagnoses include cervical radiculopathy, lumbosacral radiculopathy, shoulder tendinosis and bursitis, elbow tendinitis and bursitis, and wrist tendonitis and bursitis. Treatment to date has included diagnostic studies, medications, physical therapy, shoulder injections, status post acromioplasty and decompression on 07/17/2014 and additional therapy. A recent physician progress note dated 03/19/2015 documents the injured worker complains of increased neck and bilateral trapezius muscle spasming and radiating into the bilateral upper extremities with numbness and weakness. She also complains of low back pain radiating into the lower extremities. She has difficulty with bending, stooping, squatting and prolonged standing and walking. She continues to have left sided shoulder pain; status post left shoulder surgery, and right-sided shoulder pain as a compensatory consequence of favoring her left shoulder. She also complains of bilateral wrist and hand pain with numbness and tingling, and this is exacerbated by typing at work. On examination, there is spasm, tenderness and guarding in the paravertebral musculature of the cervical and lumbar spine with decreased range of motion on flexion and extension. There is decreased sensation over the C6, C5, and L5 and S1 dermatomes bilaterally with pain. She ambulates with an antalgic gait and has weakness with toe and heel walking bilaterally. There are positive impingement and Hawkins signs noted in the bilateral shoulders. There is positive Phalen's and reverse Phalen's sign with decreased grip strength bilaterally. Modified work duties are recommended of a 15-minute break every

two hours. Treatment requested is for EMG/NCV (electromyography/nerve conduction study) bilateral lower extremities.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **EMG/NCV (electromyography / nerve conduction study) bilateral lower extremities:**

Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): Chapter 12, "Low Back Complaints", Table 12-8, Electrodiagnostics, page 309.

**Decision rationale:** The patient had recent electrodiagnostics of all four extremities; however, no reports or results are provided and the patient continues to treat for chronic pain without new acute injury or progression of unspecified diffuse weakness without consistent neurological deficits. There were no correlating neurological deficits defined nor conclusive imaging identifying possible neurological compromise. There is no report of MRI of the lumbar spine that had identified any disc herniation, canal or neural foraminal stenosis. Per MTUS Guidelines, without specific symptoms or neurological compromise consistent with radiculopathy, foraminal or spinal stenosis, and entrapment neuropathy, medical necessity for EMG and NCV has not been established. Submitted reports have not demonstrated any symptoms or clinical findings to suggest any lumbar radiculopathy or entrapment syndrome. The EMG/NCV (electromyography / nerve conduction study) bilateral lower extremities are not medically necessary and appropriate.