

Case Number:	CM14-0156677		
Date Assigned:	09/26/2014	Date of Injury:	10/23/2013
Decision Date:	11/05/2014	UR Denial Date:	09/12/2014
Priority:	Standard	Application Received:	09/24/2014

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Ohio. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 47-year-old male who reported a date of injury of 10/23/2013. The mechanism of injury was reported as a motor vehicle accident. The injured worker had diagnoses of neck pain with headaches and left shoulder pain. Prior treatments included physical therapy and acupuncture. The injured worker had an MRI of the cervical spine on 10/23/2013 with an unofficial report revealing, left sided foraminal stenosis noted at C3-4, and severe bilateral foraminal stenosis at C4-5 and C5-6. There was a solid fusion at C5-6 and moderate spinal stenosis, left paracentral disc/osteophyte complex at C6-7. Surgeries were not indicated within the medical records provided. The injured worker had complaints of ongoing neck and left shoulder pain, and stated he was doing well with his medications. The clinical note dated 07/21/2014, noted the injured worker had a positive impingement sign. The range of motion of the left shoulder was 90 degrees of flexion and 90 degrees of abduction. Applying pressure over the pisiform area caused paresthesias into the fourth and fifth digits of the left hand, and cervical compression did not produce symptoms. However, cervical flexion and rotation did increase the symptoms down his left hand. Medications included Norco. The treatment plan included Norco; the physician's recommendation for electrodiagnostic studies to evaluate the paresthesias down the injured worker's left hand; a consultation with a different orthopedist for a second opinion; the continuation of acupuncture; and to follow-up in 1 month. The rationale provided which was due to the injured worker's paresthesias into the C7-8 distribution of the left reproduced with cervical flexion and rotation. The Request for Authorization form was received on 08/01/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient EMG/NCV: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), EMG/NCS

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179..

Decision rationale: The request for outpatient EMG/NCV is not medically necessary. The injured worker had complaints of ongoing neck and left shoulder pain, and stated he was doing well with his medications. The California MTUS/ACOEM Guidelines indicate for patients presenting with true neck or upper back problems, special studies are not needed unless a 3 or 4 week period of conservative care and observation fails to improve symptoms. Criteria for ordering imaging studies include the emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, or 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 and nerve conduction velocities, including H reflex test, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than 3 or 4 weeks. The assessment may include sensory evoked potentials if spinal stenosis or spinal cord myelopathy is suspected. The guidelines indicate electrodiagnostic studies when the neurologic examination is less clear and physiologic evidence of nerve dysfunction has been obtained. The injured worker had positive impingement signs and paresthesias into the fourth and fifth digits of the left hand. An MRI of the cervical spine from 10/23/2013 revealed left sided foraminal stenosis noted at the C3-4 level, and severe bilateral foraminal stenosis at C4-5 and C5-6. The results of the MRI support the examination findings of nerve dysfunction and neurological deficits. However, the request as submitted did not specify an extremity for the MG/NCV study. As such, the request is not medically necessary.