

Case Number:	CM13-0045243		
Date Assigned:	06/09/2014	Date of Injury:	06/14/2011
Decision Date:	07/14/2014	UR Denial Date:	10/18/2013
Priority:	Standard	Application Received:	11/12/2013

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 and Rehabilitation, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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 patient is a 45 year old male with a work injury dated 6/14/11. The diagnosis includes Status post arthroscopic right shoulder Bankart repair and loose body removal on 11/27/12. Following his surgery and rehabilitation he has persistent ache, tenderness, stiffness, numbness bilateral hands, right greater than left. Under consideration is a request for an EMG and NCS of the right upper extremity and a consultation with a physiatrist. There is an 11/7/13 supplemental report which states that the patient has an EMG in Nov. 2011 which states that he had mild median and ulnar slowing. The purpose of the EMG/NCS was to make sure that this is not progressive which could result in neuromuscular compromise. There is a progress note from orthopedic surgery dated 9/26/13 and revised on 10/9/13. The patient continues to have ache, tenderness, stiffness, and numbness bilateral hands, right greater than left. Physical exam: Normal exam findings of the left shoulder. Shoulder range of motion: Forward flexion 130 degrees on the right and 180 degrees on the left. External rotation 30 degrees on the right and 90 degrees on the left. Internal rotation 45 degrees on the right and 90 degrees on the left. Abductive strength on the right is 5-/5. Well healed arthroscopic incisions, right shoulder, decreased sensation entire right hand. There is an 11/7/13 supplemental report which states that the patient has an EMG in Nov. 2011 which states that he had mild median and ulnar slowing. The purpose of the EMG/NCS was to make sure that this is not progressive which could result in neuromuscular compromise. The documentation states that the patient has seen pain management in the past in 2012 for neck and RUE pain. Cervical imaging was performed at that time with right shoulder pain radiating hand.

IMR ISSUES, DECISIONS AND RATIONALES

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

CONSULTATION AND TREATMENT WITH PSYCHIATRIST: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management, Chapter 8 Neck and Upper Back Complaints Page(s): 92, 180.

Decision rationale: Consultation and treatment with a physiatrist is not medically necessary per the MTUS ACOEM guidelines. The ACOEM MTUS guidelines state that patients with acute neck or upper back pain alone, without findings of serious conditions or significant nerve root compromise, rarely benefit from either surgical consultation or surgery. If there is no clear indication for surgery, referring the patient to a physical medicine and rehab (PM&R) specialist may help resolve symptoms. The recent physical exam findings do not indicate that there are new neck or upper back complaints. The patient has had chronic similar symptoms. There are no physical exam findings of cervical radiculopathy and prior electrodiagnostic studies did not reveal radiculopathy. The patient has already had a diagnoses of median and ulnar nerve slowing. There is no document of a new injury. The request for consultation and treatment with a physiatrist is not medically necessary.

EMG OF RIGHT UPPER EXTREMITY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 10 Elbow Disorders (Revised 2007) Page(s): 36, 178.

Decision rationale: An EMG of the right upper extremity is not medically necessary per the MTUS ACOEM guidelines. The ACOEM MTUS guidelines state that in regard to the ulnar nerve a nerve conduction study and possibly EMG can be performed if severe nerve entrapment is suspected on the basis of physical examination, denervation atrophy is likely, and there is a failure to respond to conservative treatment. The ACOEM also states that electrodiagnostic studies can be considered to help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. The ACOEM states that in regards to carpal tunnel the most sensitive screening methods seem to be an abnormal Katz hand diagram, abnormal sensibility by Semmes-Weinstein testing, and night discomfort. Hypoesthesia in the median nerve distribution and thumb abduction strength testing also have been found to be helpful in establishing the diagnosis of CTS. The documentation indicates that an EMG/NCS of the right upper extremity is requested to make sure the patient's prior electrodiagnostic diagnoses of mild median and ulnar slowing has not progressed. The documentation does not indicate objective findings beside hand numbness (which would be present given patient's prior diagnoses of median and ulnar slowing) that require a repeat electrodiagnostic test. There are no objective findings that indicate cervical radiculopathy is suspected. There is no documentation of intrinsic atrophy or specific exam of the median or ulnar

nerve. The patient already has a diagnoses of median and ulnar slowing on prior study. Per documentation the patient has had similar symptoms dating back to 2012. The request for an EMG of the right upper extremity is not medically necessary .

NCS OF RIGHT UPPER EXTREMITY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 10 Elbow Disorders (Revised 2007) Page(s): 36, 178.

Decision rationale: The request for an NCS of the right upper extremity is not medically necessary. The ACOEM MTUS guidelines state that in regard to the ulnar nerve a nerve conduction study and possibly EMG can be performed if severe nerve entrapment is suspected on the basis of physical examination, denervation atrophy is likely, and there is a failure to respond to conservative treatment. The ACOEM also states that electrodiagnostic studies can be considered to help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. The ACOEM states that in regards to carpal tunnel the most sensitive screening methods seem to be an abnormal Katz hand diagram, abnormal sensibility by Semmes-Weinstein testing, and night discomfort. Hypoesthesia in the median nerve distribution and thumb abduction strength testing also have been found to be helpful in establishing the diagnosis of CTS. The documentation indicates that an EMG/NCS of the right upper extremity is requested to make sure the patient's prior electrodiagnostic diagnoses of mild median and ulnar slowing has not progressed. The documentation does not indicate objective findings beside hand numbness (which would be present given patient's prior diagnoses of median and ulnar slowing) that require a repeat electrodiagnostic test. There are no objective findings that indicate cervical radiculopathy is suspected. There is no documentation of intrinsic atrophy or specific exam of the median or ulnar nerve. The patient already has a diagnoses of median and ulnar slowing on prior study. Per documentation the patient has had similar symptoms dating back to 2012. The request for an NCS of the right upper extremity is not medically necessary.