

Case Number:	CM13-0046457		
Date Assigned:	06/09/2014	Date of Injury:	03/15/2013
Decision Date:	07/14/2014	UR Denial Date:	10/09/2013
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 female with a date of work injury 3/15/13. Her diagnoses include left shoulder impingement and bursitis s/p left shoulder arthroscopy subacromial decompression and left arthroscopic debridement of the glenohumeral joint, 1/20/14, left wrist median neuropathy, right lateral epicondylitis. There is a request for a left shoulder Electromyography (EMG) and left shoulder nerve conduction velocity (NCV). The shoulder is the accepted body part for worker's compensation. There is a 4/15/14 document where the patient states that her condition has improved since her last visit to the office. She complains of constant pain to the left shoulder. Movement of the left shoulder is described as painful. The patient has reduced range of motion in the left shoulder. On physical exam of the left shoulder there is tenderness upon palpation over the anterior, superior and lateral aspect. The treatment plan includes continuing physical therapy. A 3/4/14 document states that in approximately March 2011 the patient began to have left shoulder pain which she believes was due to the constant lifting and carrying boxes overhead. In approximately October 2012 the patient began to have right wrist/hand pain which she believes was due to constant use of holding the scanner. In early 2013, the patient began to have left wrist/hand pain which she believes may be due to lifting boxes. Record review indicates that a 6/26 left shoulder magnetic resonance imaging (MRI) revealed a 1. Mild inferolateral orientation of the acromion, causing impingement on the distal supraspinatus tendon with signal changes in the tendon and partial thickness undersurface tear without retraction or muscle atrophy. 2. Partial thickness tear near the site of insertion of the subscapularis tendon without retraction or muscle atrophy. 3. No glenoid labral tear. A 12/3/13 primary treating physician progress report states that the patient continues to experience symptoms in her left shoulder. The pain is constant in terms of frequency. She describes the pain

as severe and she has difficulty sleeping due to the pain. The pain radiates to the neck. The pain increases with overhead activities. The pain increases with movement. She also experiences pain in her bilateral wrists, greater on the right. The pain is constant in terms of frequency. She feels numbness in both hands. She has loss of strength in her right hand. The pain increases with movement. Physical exam findings reveals tenderness to palpation over the left trapezius, left rhomboid, as well as the anterior, lateral, posterior and superior aspects of the shoulder. Pain is noted with flexion, abduction, and external rotation. Neer testing and Hawkin's sign are positive. In the right hand/wrist there is normal temperature and color. She is able to make a full fist. There is tenderness to palpation on the dorsal and radial aspects. Mild numbness is noted over the right hand and five fingers. Examination of the left hand/wrist reveals normal temperature and color. She is able to make a full fist. There is tenderness to palpation over the dorsal and radial aspects, greater on the right. There is an operative report dated 1/20/14 for left shoulder surgery, for a left shoulder arthroscopy subacromial decompression and left arthroscopic debridement of the glenohumeral joint, 1/20/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

ELECTROMYOGRAPHY OF THE LEFT SHOULDER: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints Page(s): 207-9, 178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints Page(s): 178, 213.

Decision rationale: Electromyography of the left shoulder is not medically necessary per the California Medical Treatment Utilization Schedule (MTUS) and American College of Occupational and Environmental Medicine (ACOEM) guidelines. The ACOEM MTUS guidelines shoulder chapter states that rarely electromyography (EMG) and nerve conduction studies (NCS) can be done as part of a shoulder evaluation for a suprascapular nerve injury if the patient has severe cuff weakness unaccompanied by a rotator cuff tear. The documentation submitted does not indicate atrophy in the left shoulder. The documentation does indicate that the patient has had left rotator cuff surgery. The ACOEM guidelines also states that (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. The request is for a nerve conduction study as well as an EMG of the left shoulder. Without evidence of focal shoulder nerve compromise on physical exam the request for electromyography of the left shoulder is not medically necessary.

NERVE CONDUCTION VELOCITY OF THE LEFT SHOULDER: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints Page(s): 207-9, 178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints Page(s): 178, 213.

Decision rationale: The American College of Occupational and Environmental Medicine (ACOEM) California Medical Treatment Utilization Schedule (MTUS) guidelines shoulder chapter states that rarely electromyography (EMG) and nerve conduction studies (NCS) can be done as part of a shoulder evaluation for a suprascapular nerve injury if the patient has severe cuff weakness unaccompanied by a rotator cuff tear. The documentation submitted does not indicate atrophy in the left shoulder. The documentation does indicate that the patient has had left rotator cuff surgery. The ACOEM guidelines also states that 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. The request is for a nerve conduction study as well as an EMG of the shoulder. Without evidence of focal shoulder nerve compromise on physical exam the request for a nerve conduction velocity of the left shoulder is not medically necessary.