

Case Number:	CM13-0046740		
Date Assigned:	12/27/2013	Date of Injury:	04/19/2011
Decision Date:	09/30/2014	UR Denial Date:	09/30/2013
Priority:	Standard	Application Received:	11/01/2013

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 & Rehabilitation and is licensed to practice in California. 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 49-year-old female who has submitted a claim for impingement of the left shoulder and bilateral carpal tunnel syndrome associated with an industrial injury date of April 19, 2011. Medical records from 2012 through 2013 were reviewed, which showed that the patient complained of left shoulder, left wrist and left hand pain. Examination showed positive Hawkin's, Neer's and O'Brien's tests. The left shoulder had decreased ROM. An MRI of the cervical spine on 2/27/12 revealed, "at C3-4 a broad-based disc bulge, measuring 2.0 millimeters. There was no neural foraminal encroachment. The C2-3, C4-5, C5-6, C6-7, and C7-T1 levels were normal." An MRI of the left shoulder dated 4/6/12 showed "acromioclavicular (AC) osteoarthritis, subdeltoid/subacromial bursitis, supraspinatus tendinitis, infraspinatus tendinitis with increased signal intensity within the tendon itself." An MRI of the left wrist from 5/6/12 showed subchondral cysts within the lunate and triquetrum bone. An undated electrodiagnostic study, according to the UR, documented mild carpal tunnel syndrome of the right hand. Treatment to date has included 18 sessions of therapy for the left hand and wrist, a cortisone injection in the left ulnar side of the wrists, a right wrist DeQuervain's injection, medications, work restrictions, brace/support and shockwave treatment. Utilization review from September 30, 2013 denied the request for Electromyography (EMG) of the bilateral upper extremities and Nerve Conduction Study (NCS) of the Bilateral Upper Extremities because the patient already had prior nerve conduction studies which demonstrated mild carpal tunnel syndrome affecting the right hand.

IMR ISSUES, DECISIONS AND RATIONALES

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

ELECTROMYOGRAPHY (EMG) OF THE BILATERAL UPPER EXTREMITIES:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 261, 269.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 537. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Electromyography.

Decision rationale: According to page 238 of the CA MTUS ACOEM Practice Guidelines, EMG is recommended if cervical radiculopathy is suspected as a cause of lateral arm pain or if severe nerve entrapment is suspected on the basis of physical examination and denervation atrophy is likely. Moreover, guidelines do not recommend EMG before conservative treatment. In this case, an EMG of the upper extremities was requested. Patient complained of pain in the left shoulder, left wrist and left hand. Physical examination of the shoulder showed decreased range of motion and positive Neer's, Hawkin's and O'Brien tests. Motor strength, sensation and deep tendon reflex testing were not documented. The clinical manifestations were not consistent with focal neurologic dysfunction to warrant EMG. Furthermore, an undated electrodiagnostic study already documented right hand mild carpal tunnel syndrome. Therefore, the request for Electromyography (EMG) of the bilateral upper extremities is not medically necessary.

NERVE CONDUCTION STUDY (NCS) OF THE BILATERAL UPPER EXTREMITIES:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 261, 269.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Nerve Conduction Studies Other Medical Treatment Guideline or Medical Evidence: Nerve Conduction Studies in Polyneuropathy: Practical Physiology and Patterns of Abnormality, Acta Neurol Belg 2006 Jun; 106 (2): 73-81.

Decision rationale: CA MTUS ACOEM Guidelines state that appropriate electrodiagnostic studies may help differentiate between carpal tunnel syndrome and other conditions, such as cervical radiculopathy. These include nerve conduction studies, or in more difficult cases, electromyography may be helpful. Moreover, ODG states that NCS is not recommended to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but is recommended if the EMG is not clearly consistent with radiculopathy. A published study entitled "Nerve Conduction Studies in Polyneuropathy" cited that NCS is an essential part of the work-up of peripheral neuropathies. Many neuropathic syndromes can be suspected on clinical grounds, but optimal use of nerve conduction study techniques allows diagnostic classification and is therefore crucial to understanding and separation of neuropathies. In this case, the patient complained left shoulder, left wrist and left

hand pain. The complaints are poorly classified in terms of location, radiation, quality of pain, intensity, etc. Physical examination of the shoulder showed decreased range of motion and positive Neer's, Hawkin's and O'Brien tests. Motor strength, sensation and deep tendon reflex testing were not documented. The left upper extremity evaluation was not documented to support the need for bilateral upper extremity NCV. Moreover, the MRI findings did not demonstrate evidence of specific nerve root impingement. Finally, a prior electrodiagnostic study already documented the presence of mild right carpal tunnel syndrome. Therefore, the request for Nerve Conduction Velocity (NCV) Bilateral Upper Extremities is not medically necessary.