

<b>Case Number:</b>	CM14-0003674		
<b>Date Assigned:</b>	01/31/2014	<b>Date of Injury:</b>	02/08/2012
<b>Decision Date:</b>	06/20/2014	<b>UR Denial Date:</b>	12/11/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/09/2014

### 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 Occupational Medicine 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 27 year old male who was injured on 02/08/2012. It was reported that the patient was involved in motor vehicle accident. Medications as of 01/23/2014 include Hydrocodone 10/325 one to two every six hours, over-the-counter Benadryl, Coumadin and enoxaparin sodium injections 100 mg/ml. Diagnostic studies reviewed include x-ray of the clavicle 2 views dated 03/21/2013 demonstrates healing of the left clavicle fracture with plate screw fixation device. There is no evidence of hardware failure. There is no abnormal lucency around the hardware. Occupational therapy evaluation dated 11/19/2013 reports the patient presents with decreased functional use of left upper extremity. He complains that his pain and discomfort is in the left wrist, elbow, and hand. The patient suffers from left brachial plexopathy which is severe; C2 vertebral fracture; C1-C2ligamentous injury; left axillary transaction status post stent; left clavicle fracture status post ORIF; and fractures of the ribs 5 through 7 on the left. He rates his pain as a 2 and it is constant with associated numbness. On exam, his range of motion is absent in the left upper extremity. The patient has difficulty with bilateral hand activities due to non-functional left upper extremity. On assessment, there is decreased functional use of left upper extremity and the patient needs dynamic splinting and modification. It is believed the patient will benefit from hand therapy. The plan is a referral to a hand specialist for dynamic splinting/modification and continued therapy. Physical therapy re-evaluation summary dated 01/30/2014 reports the patient is being seen for his left shoulder for the first time since 09/2013. He has limited use of his left upper extremity, tightness about the left shoulder and peri-scapular region. On exam, AROM of the left shoulder reveals elevation to 105; extension to 0; Abduction to 70. He is unable to rotation externally and he can rotate internally towards to the body. PROM left shoulder reveals flexion to 160; abduction to 80 GH; ER 25/30/30 at 0/45/90 abduction; IR to 60. MMT is reduced except in the upper trapezius muscle. On inspection of the

left scapula, posture is upward and medially rotated; with active elevation, excessive and early upward rotated and tipping anteriorly. Progress report dated 11/05/2013 documents a request for an electrodiagnostic study of the left upper extremity and left lower extremity; twelve sessions of physical therapy targeting his left upper extremity, and active sling for his left upper extremity.

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

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

#### **EMG/NCV STUDIES OF THE LEFT UPPER EXTREMITIES: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE 2ND EDITION (2004), CHAPTER 11,

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179. Decision based on Non-MTUS Citation MTUS Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8) pages 177-179.

**Decision rationale:** According to the MTUS/ACOEM Guidelines, regarding the criteria for ordering imaging studies are: Emergence of a red flag; Physiologic evidence of tissue insult or neurologic dysfunction; Failure to progress in a strengthening program intended to avoid surgery; Clarification of the anatomy prior to an invasive procedure. Furthermore the MTUS/ACOEM Guidelines, states, "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 (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." In this case, the patient is apparently scheduled to undergo repeat stent versus bypass graft of the left upper extremity. LUE NCV/EMG is being requested to establish left pronator teres and pronator quadratus function prior to possible tendon transplant to wrist/hand extensors, whose function is diminished due to radial nerve palsy. However, limited records (most notes provided are neuropsychiatric reports; notes from [REDACTED] are not provided) note improvement in left upper extremity range of motion and strength with ongoing physical therapy. Left forearm pronation and pronator teres/pronator quadratus strength are noted to be normal. There is no mention of medial nerve injury in the record. Prior LUE NCV/EMG studies, if any, are not available for review. Provided medical records do not establish the necessity of the imaging studies. Therefore, the requests for EMG/NCV of the left upper extremities are not medically necessary and appropriate.

#### **ELECTROMYOGRAPHY OF THE LEFT UPPER EXTREMITY: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE 2ND EDITION (2004), CHAPTER 11,

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

**Decision rationale:** This is a request for left upper extremity NCV/EMG for a 27 year old male who suffered severe injuries from an MVA on 2/8/12 including left brachial plexopathy and left axillary artery transection. The patient is also apparently scheduled to undergo repeat stent versus bypass graft of the left upper extremity. LUE NCV/EMG is apparently being requested to establish left pronator teres and pronator quadratus function prior to possible tendon transplant to wrist/hand extensors, whose function is diminished due to radial nerve palsy. However, limited records (most notes provided are neuropsychiatric reports; notes from [REDACTED] are not provided) note improvement in left upper extremity range of motion and strength with ongoing physical therapy. Left forearm pronation and pronator teres/pronator quadratus strength are noted to be normal. There is no mention of medial nerve injury in the record. Prior LUE NCV/EMG studies, if any, are not available for review. Provided medical records do not establish the necessity of the procedure. Further, if deemed necessary at a later date, the study should probably be performed after the patient's upcoming left upper extremity vascular surgery.