

Case Number:	CM14-0106820		
Date Assigned:	08/06/2014	Date of Injury:	09/23/2008
Decision Date:	09/10/2014	UR Denial Date:	05/20/2014
Priority:	Standard	Application Received:	06/19/2014

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 and Rehabilitation and is licensed to practice in Nevada. 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 records, presented for review, indicate that this 38 year old female was reportedly injured on September 23, 2008. The mechanism of injury is undisclosed. The most recent progress note, dated June 6, 2014, indicated that there were ongoing complaints of left shoulder pain. Current medications include Mobic, Trazodone, Lunesta, and Norco. The physical examination demonstrated full but painful range of motion of the cervical spine, tenderness noted along the paraspinal muscles and the spinous processes at C3 and C4, full range of motion of the right shoulder and no tenderness; examination of the left shoulder noted slightly decreased range of motion and a positive Hawkins test, Neer's test, empty can test, and crank test, tenderness over the acromioclavicular joint, biceps groove, glenohumeral joint, and subdeltoid bursa, posteriorly, there was tenderness over the trapezius and rhomboids, decreased sensation over the medial antebrachial cutaneous nerve and ulnar distribution on the left side. Diagnostic imaging studies were not reviewed during this visit. Previous treatment included a left shoulder and right knee arthroscopy. A request was made for electromyography and nerve conduction studies of the left upper extremity as well as pain management counseling and was denied in the preauthorization process on May 20, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electromyography left upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): (electronically sited).

Decision rationale: According to the attached medical record, the injured employee has had previous electromyography (EMG) and nerve conduction studies (NCV) performed of the left upper extremity. While there were abnormal findings on the recent progress note dated June 6, 2014, there is no justification mentioned for requesting repeat studies at this time. Therefore, this request for electromyography of the left upper extremity is not medically necessary and appropriate.

Nerve Conduction Studies left upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): (electronically cited).

Decision rationale: According to the attached medical record, the injured employee has had previous electromyography (EMG) and nerve conduction studies (NCV) studies performed of the left upper extremity. While there were abnormal findings on the recent progress note dated June 6, 2014, there is no justification mentioned for requesting repeat studies at this time. Therefore, this request for NCV of the left upper extremity is not medically necessary and appropriate.

Pain Management counseling times six (6) visits: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, OMPG Page 127 (ODG) Official Disability Guidelines Neck & Upper Back office visits.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7 - Independent Medical.

Decision rationale: According to the medical record, the injured employee has been previously seen by pain management. Additionally, there is no documentation in the attached medical record that the injured employee's symptoms are not controlled with current treatment program that would require specialty care from pain management. Without additional justification, the requests for six visits of pain management counseling are not medically necessary and appropriate.