

Case Number:	CM14-0013660		
Date Assigned:	02/26/2014	Date of Injury:	06/30/2000
Decision Date:	06/26/2014	UR Denial Date:	01/17/2014
Priority:	Standard	Application Received:	02/03/2014

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 Neurology, and is licensed to practice in Texas. 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 47-year-old male injured worker reported an injury on June 30, 2000. The mechanism of injury was not provided in the documentation. Per the EMG study dated July 1, 2009, the injured worker was found to have a moderate bilateral focal median neuropathy at the carpal tunnel and a mild focal ulnar neuropathy at the left elbow. An MR arthrogram of the right shoulder dated April 11, 2012 noted prior subacromial decompression, acromioplasty, and resection of the distal clavicle; full thickness/full width tear of the supraspinatus tendon at the foot print of the medial retraction of the torn fibers; near full thickness/full width tear of the infraspinatus tendon at the foot print with medial retraction of the torn fibers; moderate atrophy of the supraspinatus and infraspinatus muscles; mild atrophy of the teres minor muscle; severe tendinosis of the subscapularis tendon with low grade partial thickness articular sided tear of the upper fibers adjacent to its lesser tuberosity attachment; severe tendinosis of the long head of the biceps tendon at the pulley; focal chondral loss involving the inferior portion of the glenoid with interosseous ganglion cyst; and superior migration of the humeral head with slight posterior subluxation. The progress note dated January 8, 2014 indicated the injured worker reported increased signs and symptoms of numbness and tingling to the bilateral upper extremities in his digits since his last office visit in December. The injured worker also complained of pain to the right shoulder. Objective findings include decreased grip and positive Tinel's to the wrist and elbow bilaterally, and decreased range of motion and weakness to the right shoulder. Diagnosis for the injured worker include brachial neuritis or radiculitis, displacement of intervertebral disc site (unspecified) without myelopathy, carpal tunnel syndrome, and bursitis of the right shoulder. The request for authorization for medical treatment was not provided in the documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

REPEAT EMG BILATERAL UPPER EXTREMITY: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM, CHAPTER NECK AND UPPER BACK COMPLAINTS,

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

Decision rationale: The Neck and Upper Back Complaints Chapter of the ACOEM Practice Guidelines states when the neurological examination is less clear however, further psychological evidence of nerve dysfunction can be obtained before ordering an imaging study. EMG and NCV including H-reflex test may help identify subtle, focal, neurologic dysfunction in patients with neck or arm symptoms or both lasting more than three to four weeks. There was a lack of documentation regarding any objective changes in the injured worker's upper extremities. The EMG previously noted bilateral carpal tunnel syndrome and ulnar neuropathy at the left elbow. There was a lack of documentation regarding other conservative treatments such as physical therapy that the injured worker had attempted. The request for an EMG of the bilateral upper extremities is not medically necessary or appropriate.

REPEAT NCV BILATERAL UPPER EXTREMITY: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM, CHAPTER NECK AND UPPER BACK COMPLAINTS,

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

Decision rationale: The Neck and Upper Back Complaints Chapter of the ACOEM Practice Guidelines state criteria for ordering imaging studies are emergence of a red flag, physiological evidence of tissue insult or neurological dysfunction, failure to progress in a strengthening program intended to avoid surgery, or clarification of anatomy prior to an invasive procedure. When a neurological exam is less clear however, further physiological evidence of nerve dysfunction can be obtained before ordering an imaging study. EMG and NCV including H-reflex tests may help identify subtle, focal, neurological dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. There was a lack of documentation regarding any objective changes in the injured worker's upper extremities. There was a lack of documentation regarding other conservative treatment such as physical therapy. The request for an NCV of the bilateral upper extremities is not medically necessary or appropriate.