

Case Number:	CM14-0173044		
Date Assigned:	10/23/2014	Date of Injury:	03/02/2013
Decision Date:	12/02/2014	UR Denial Date:	10/13/2014
Priority:	Standard	Application Received:	10/20/2014

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, has a subspecialty in Preventive Medicine and is licensed to practice in Iowa. 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:

This patient is a 58 year old employee with date of injury of 03/02/2013. Medical records indicate the patient is undergoing treatment for right shoulder pain, lumbar sprain and left knee contusion. Subjective complaints include pain on the outside and top of the shoulder, shoulder weakness. Patient had PT of the right shoulder and a rotator cuff injection, neither which provided any relief. Objective findings include patellofemoral pain, no effusion, negative McMurray's, left shoulder elevation of 160, right of 120, external rotation of 40 on left, 30 on the right, internal rotation is T10 on left and L2 on the right, tenderness on palpation over the greater tuberosity, and positive Neer and Hawkins impingement signs. Treatment has consisted of home exercise regimen, PT of the shoulder, naproxen, Vicodin, ibuprofen and subacromial space injection of 5ml of 1% lidocaine and 40mg Kenalog. MRI conducted on 09/30/2014 showed moderate acromioclavicular joint arthrosis and subacromial spur, anterior bursal surface partial tear of about 5mm in dimension suggestive of a bursal-sided rotator cuff tear. The utilization review determination was rendered on 10/13/2014 recommending non-certification of nerve conduction velocity (NCV) of the right shoulder and an electromyography (EMG) of the right shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Nerve Conduction Velocity (NCV) of the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Electrodiagnostic Testing (EMG/NCV)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260-262. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Electrodiagnostic testing (EMG/NCS)

Decision rationale: ACOEM States "Appropriate electrodiagnostic studies (EDS) may help differentiate between carpal tunnel syndrome (CTS) and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful." ODG states "Recommended needle EMG or NCS, depending on indications. Surface EMG is not recommended. Electromyography (EMG) and Nerve Conduction Studies (NCS) are generally accepted, well-established and widely used for localizing the source of the neurological symptoms and establishing the diagnosis of focal nerve entrapments, such as carpal tunnel syndrome or radiculopathy, which may contribute to or coexist with CRPS II (causalgia), when testing is performed by appropriately trained neurologists or physical medicine and rehabilitation physicians (improperly performed testing by other providers often gives inconclusive results). As CRPS II occurs after partial injury to a nerve, the diagnosis of the initial nerve injury can be made by electrodiagnostic studies". ODG further clarifies "NCS is not recommended, but EMG is recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious." The treating physician does not document evidence of radiculopathy, muscle atrophy, and abnormal neurologic findings. The above ACOEM and ODG criteria for an NCV of the upper extremities have not been met. As such the request for NCV of the right upper extremity is not medically necessary.

Electromyography (EMG) of the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Electrodiagnostic Testing (EMG/NCV)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260-262. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Electrodiagnostic testing (EMG/NCS)

Decision rationale: ACOEM States "Appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful." ODG states "Recommended needle EMG or NCS, depending on indications. Surface EMG is not recommended. Electromyography (EMG) and Nerve Conduction Studies (NCS) are generally accepted, well-established and widely used for localizing the source of the neurological symptoms and establishing the diagnosis of focal nerve entrapments, such as carpal tunnel syndrome or radiculopathy, which may contribute to or

coexist with CRPS II (causalgia), when testing is performed by appropriately trained neurologists or physical medicine and rehabilitation physicians (improperly performed testing by other providers often gives inconclusive results). As CRPS II occurs after partial injury to a nerve, the diagnosis of the initial nerve injury can be made by electrodiagnostic studies". ODG further clarifies "NCS is not recommended, but EMG is recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious." The treating physician does not document evidence of radiculopathy, muscle atrophy, and abnormal neurologic findings. The above ACOEM and ODG criteria for an EMG of the upper extremities have not been met. As such the request for EMG of the right upper extremity is not medically necessary.