

Case Number:	CM14-0022689		
Date Assigned:	06/11/2014	Date of Injury:	10/22/2009
Decision Date:	08/12/2014	UR Denial Date:	01/30/2014
Priority:	Standard	Application Received:	02/24/2014

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 Illinois. 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 injured worker is a 50-year-old male who reported an injury on 10/22/2009, due to pushing pallets at work. The injured worker complained of pain in the neck and left shoulder that radiates down to the left upper extremity. The pain is associated with numbness and tingling in the bilateral hands, as well as weakness in the bilateral arms. The injured worker also complained that the pain is constant in frequency and severe in intensity. On a scale of 1 to 10, the injured worker rates the severity of the pain as a 9/10. The injured worker describes the pain as sharp, throbbing, dull, achy, shooting, electric-like, burning, and pins and needles sensation. Per physical examination dated 01/24/2014, range of motion of the cervical spine is restricted with flexion limited to 20 degrees, extension limited to 30 degrees, lateral rotation to the left limited to 30 degrees, and lateral rotation to the right at 30 degrees. There was tenderness and spasms of the paravertebral muscles noted on both sides; Spurling's maneuver causes pain in the muscle of the neck, but no radicular symptoms. The range of motion to the shoulder was restricted with flexion at 75 degrees, abduction at 80 degrees, internal rotation behind body limited to 45 degrees (L4), and external rotation limited to 70 degrees. The patient's Hawkins test is positive, his Neer's test is positive and his drop arm test is positive. There was tenderness on palpation noted in the biceps groove and subdeltoid bursa. The injured worker's past treatments and diagnostics was an MRI of the left shoulder performed on 11/13/2009 which revealed a near full-thickness partial insertional tear of the rotator cuff without evidence of tendon retraction. There was an abnormal signal at the base of the superior labrum with adjacent glenoid cyst and small soft tissue cysts suggestive of superior labral tear with associated paralabral cyst extending into the glenoid and soft tissue. There was an MRI scan of the cervical spine. The injured worker also underwent an electromyography/nerve conduction velocity study of the bilateral upper extremities which revealed right cervical spine radiculopathy and bilateral carpal tunnel

syndrome. The injured worker's medication was Alprazolam 0.5 mg, Ketamine 5% cream, Lamotrigine 25 mg, Opana ER 40 mg, Temazepam 7.5 mg, Trazodone 50 mg, Flexeril 10 mg, and Hydrocodone 10/325 mg, and Neurontin 600 mg. The injured worker's diagnoses include cervical strain with radicular pain, near full-thickness rotator cuff tear, possible superior labral tear with paralabral cyst formation, and degenerative changes of the AC joint of the left shoulder. The treatment plan was for electromyography with nerve conduction velocity of the bilateral upper extremities. The request for authorization form was not provided with documentation. The rationale for request is to rule out cervical spine radiculopathy versus peripheral nerve entrapment given objective findings of extremity sensory impairment and subjective symptoms of numbness and tingling.

IMR ISSUES, DECISIONS AND RATIONALES

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

ELECTROMYOGRAPHY /NERVE CONDUCTING VELOCITY OF BILATERAL UPPER EXTREMITIES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

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

Decision rationale: The injured worker complained of neck pain that radiates down to the left upper extremity and left shoulder pain. The California MTUS ACOEM Guidelines indicate that electrodiagnostic studies may help differentiate between carpal tunnel syndrome and cervical radiculopathy. 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, and clarification of the anatomy prior to an invasive procedure. Unequivocal findings that identify specific nerve compromise on a neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. Conservative treatments were initiated including a course of physical therapy which provided the injured worker with no significant pain relief. The injured worker underwent an electromyography/nerve conduction velocity study on 02/07/2011 which revealed right cervical spine radiculopathy and bilateral carpal tunnel syndrome. There was lack of clinical documentation of neurological deficits, increased weakness, decreased range of motion or functional deficits, or worsening pain on physical examination to warrant repeat testing. Furthermore, there was lack of documentation regarding conservative care. As such, the request is not medically necessary.