

Case Number:	CM14-0023588		
Date Assigned:	06/24/2014	Date of Injury:	05/20/2011
Decision Date:	07/29/2014	UR Denial Date:	01/24/2014
Priority:	Standard	Application Received:	02/25/2014

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 & Rehabilitation, 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 injured worker is a 57-year-old female who reported an injury on 05/20/2011. The mechanism of injury was a fall. The diagnoses included internal derangement of the right shoulder, status post arthroscopic surgery, compensatory pain of the left shoulder, internal derangement of the left knee status post arthroscopy, chronic cervical pain, chronic lumbar spine pain, and lumbar disc herniation. Previous treatments include surgery, medication, injections, physical therapy, and acupuncture. Within the clinical note dated 12/04/2013 it was reported the injured worker complained of bilateral shoulder pain. She states that the right shoulder hurts more than the left. She complained that her left shoulder began to hurt just prior to undergoing the right shoulder surgery. The injured worker complained shoulder pain increases with overhead activity. The patient complained of distal right upper extremity pain with numbness and tingling. She reported the numbness and tingling radiate to the middle 3 digits in the right hand with burning pain in the forearm and upper arm. Upon the physical examination of the right shoulder, the provider noted abduction and flexion at 140 degrees and extension at 50 degrees. The provider noted abduction and flexion of the left shoulder at 140 degrees and extension at 50 degrees. The injured worker had a positive impingement sign on both shoulders. The provider indicated the injured worker had spasms and guarding at the base of the cervical spine to the right cervical paravertebral region. The provider noted he recommended electrodiagnostic studies given the distal right upper extremity complaints of pain, numbness, and tingling. The provider requested for an electromyography of the left upper extremity and an electromyography of the right upper extremity given the distal right upper extremity complaints of numbness and tingling.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETRO ELECTROMYOGRAPHY (EMG) LEFT UPPER EXTREMITY: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines Neck & Upper Back (EMG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-269.

Decision rationale: The request for retro electromyography of the left upper extremity is not medically necessary. The injured worker complained of bilateral shoulder pain. She stated the right hurt more than the left. The injured worker reported left shoulder pain began prior to undergoing surgery of the right shoulder. The injured worker complained of pain with overhead activity. The California MTUS/American College of Occupational and Environmental Medicine Guidelines recommend an electromyography in cases of peripheral nerve impingement. If no improvement or worsening has occurred within 4 to 6 weeks, electrical studies may be indicated. The clinical documentation submitted indicates objective findings in the physical examination and imaging are consistent with nerve root involvement. As such, EMG of the left upper extremity would not be medically warranted. Therefore, the retro request for electromyography of the left upper extremity is not medically necessary.

RETRO ELECTROMYOGRAPHY (EMG) RIGHT UPPER EXTREMITY: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines Neck & Upper Back (EMG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-269.

Decision rationale: The request for retro electromyography of the right upper extremity is not medically necessary. The injured worker complained of bilateral shoulder pain. She stated the right hurt more than the left. The injured worker reported left shoulder pain began prior to undergoing surgery of the right shoulder. The injured worker complained of pain with overhead activity. The California MTUS/American College of Occupational and Environmental Medicine Guidelines recommend an electromyography in cases of peripheral nerve impingement. If no improvement or worsening has occurred within 4 to 6 weeks, electrical studies may be indicated. The clinical documentation submitted reports the diagnosis of nerve root involvement from the physical examination and imaging studies. As such, an EMG of the right upper extremity would not be medically warranted. Therefore, the retrospective request for an electromyography of the right upper extremity is not medically necessary.

