

Case Number:	CM14-0061013		
Date Assigned:	07/09/2014	Date of Injury:	12/14/2011
Decision Date:	09/03/2014	UR Denial Date:	04/28/2014
Priority:	Standard	Application Received:	05/01/2014

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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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 47-year-old female with a reported injury on 12/14/2011. The mechanism of injury occurred when the injured worker was pulling a patient up in bed. The injured worker's diagnoses consisted of residual right shoulder distal clavicle excision, acromioplasty, and bursectomy on 08/17/2012; postoperative arthrofibrosis with painful restriction of range of motion; severe myofascial pain syndrome in the right scapula, cervical and pectoral muscles; muscle spasm with limited range of motion; chronic headaches with migraine qualities; radiating paresthesias along the distribution of the right brachial plexus into the right upper extremity; and sensitivity to Vicodin, tramadol, and Lyrica. The injured worker has had previous treatments including anti-inflammatories, pain medications, injections, physical therapy, and bracing. The injured worker has had a previous MRI of the cervical spine. The official MRI was not provided for clinical review. She had an examination on 04/07/2014 where she reported that Pennsaid solution applied to her hands, elbows, and shoulders had quelled her symptoms by over 50% and Flector patch reduced the severity of her pain in her upper back as well. She did do her home exercise program with a ball and walking daily. It was reported that her activities of daily living were limited due to the severity of her chronic pain. Upon examination of her upper cervical spine, it was noted that she had upper cervical thoracic kyphosis measured at 35 degrees. The posterior and lateral facets remained tender to deep pressure. There was tenderness to palpation at her myofascial trigger points with twitch responses in the levator scapula, trapezius, and rhomboid muscles causing radiating pain to the posterior scapula and neck. Her range of motion was significantly limited. Finkelstein's test was negative bilaterally, Tinel's test was positive on the right side and the Phalen's test was positive on the right side as well. There was an MRI of the cervical spine that was approved on 03/19/2014, although the results of that examination were not provided for review. The injured

worker also had an updated examination on 07/02/2014 where her range of motion of her shoulders had decreased since the previous examination on 04/07/2014. Her range of motion flexion to her left side was 170 degrees and the right side was 90 degrees, extension was 50 degrees on the left and on the right was 20 degrees, abduction was 160 degrees on the left and 80 degrees on the right, adduction was 30 degrees on the left and 10 degrees on the right, the internal rotation was 80 degrees on the left and 60 degrees on the right, and external rotation was 100 degrees on the left and 70 degrees on the right. There were no other changes noted in the examination. The medications list included Cymbalta, Pennsaid solution, omeprazole, Cozaar, atenolol, losartan, amlodipine, tramadol, Flector patch, FeSO₄, and baclofen. The recommended plan of treatment is for trigger point injections to the right cervical trapezius, levator scapula, and rhomboid muscles; an MRI of the cervical spine; an electromyography and nerve conduction studies of both upper extremities to evaluate for causes of numbness and paresthesias in the upper extremities; and a right wrist splint. The request for authorization was signed and dated for 04/09/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electromyogram (EMG) of the right upper extremity: 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 request for the electromyography for the right upper extremity is non-certified. The California MTUS/ACOEM Guidelines note when the injured worker's neurological examination is less clear, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography tests may be helpful to identify subtle focal neurological dysfunction in patients with neck or arm symptoms, or both, lasting more than 3 to 4 weeks. Upon examination, muscle strength in the upper extremities was 5/5 on the left side and 4/5 on the right side. The nerve sensation to her arms was normal (5/5) bilaterally to the C5, C6, C7, and C8 dermatomes. Sensation was slightly decreased (4/5) to the median nerve on the right. The injured worker has decreased strength to the right upper extremity; however, there is a lack of documentation of findings indicative of neurologic deficit to the upper extremities. The physician noted an MRI of the cervical spine was previously performed; however, the results of the imaging was not provided within the documentation. Therefore, the EMG to the right upper extremity is non-certified.

Electromyogram (EMG) of the left upper extremity: 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 request for the electromyography for the left upper extremity is non-certified. The California MTUS/ACOEM Guidelines note when the injured worker's neurological examination is less clear, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography tests may be helpful to identify subtle focal neurological dysfunction in patients with neck or arm symptoms, or both, lasting more than 3 to 4 weeks. Upon examination, muscle strength in the upper extremities was 5/5 on the left side and 4/5 on the right side. The nerve sensation to her arms was normal (5/5) bilaterally to the C5, C6, C7, and C8 dermatomes. Sensation was slightly decreased (4/5) to the median nerve on the right. The injured worker has decreased strength to the right upper extremity; however, there is a lack of documentation of findings indicative of neurologic deficit to the upper extremities. The physician noted an MRI of the cervical spine was previously performed; however, the results of the imaging was not provided within the documentation. Therefore, the EMG to the left upper extremity is non-certified.

Nerve Conduction Study (NCS) of the right upper extremity: 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 based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & upper back, Nerve conduction studies (NCS).

Decision rationale: The request for the nerve conduction study for the right upper extremity is non-certified. The California MTUS/ACOEM Guidelines note when the injured worker's neurological examination is less clear, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. The Official Disability Guidelines note nerve conduction studies are not recommended to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs. NCV is recommended if the EMG is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely based on the clinical exam. Upon examination, muscle strength in the upper extremities was 5/5 on the left side and 4/5 on the right side. The nerve sensation to her arms was normal (5/5) bilaterally to the C5, C6, C7, and C8 dermatomes. Sensation was slightly decreased (4/5) to the median nerve on the right. The injured worker has decreased strength to the right upper extremity; however, there is a lack of documentation of findings indicative of neurologic deficit to the upper extremities. The physician noted an MRI of the cervical spine was previously performed; however, the results of the imaging was not provided within the documentation. The guidelines note NCV is recommended if EMG is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely based on the clinical exam. There is a

lack of documentation demonstrating findings upon physical examination indicative of peripheral neuropathies to the upper extremities. Therefore, the NCS to the right upper extremity is non-certified.

Nerve Conduction Study (NCS) of the left upper extremity: 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 based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & upper back, Nerve conduction studies (NCS).

Decision rationale: The request for the nerve conduction study for the left upper extremity is non-certified. The California MTUS/ACOEM Guidelines note when the injured worker's neurological examination is less clear, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. The Official Disability Guidelines note nerve conduction studies are not recommended to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs. NCV is recommended if the EMG is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely based on the clinical exam. Upon examination, muscle strength in the upper extremities was 5/5 on the left side and 4/5 on the right side. The nerve sensation to her arms was normal (5/5) bilaterally to the C5, C6, C7, and C8 dermatomes. Sensation was slightly decreased (4/5) to the median nerve on the right. The injured worker has decreased strength to the right upper extremity; however, there is a lack of documentation of findings indicative of neurologic deficit to the upper extremities. The physician noted an MRI of the cervical spine was previously performed; however, the results of the imaging was not provided within the documentation. The guidelines note NCV is recommended if EMG is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely based on the clinical exam. There is a lack of documentation demonstrating findings upon physical examination indicative of peripheral neuropathies to the upper extremities. Therefore, the NCS to the left upper extremity is non-certified.