

Case Number:	CM14-0089466		
Date Assigned:	07/23/2014	Date of Injury:	01/14/2005
Decision Date:	09/24/2014	UR Denial Date:	05/14/2014
Priority:	Standard	Application Received:	06/13/2014

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 Louisiana. 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 patient is a 49-year-old female who was injured on 01/14/2005. The mechanism of injury is unknown. The patient underwent cervical fusion in 2007. She has been treated conservatively with physical therapy and steroid injections. Progress report dated 04/29/2014 indicates the patient presented with complaints of left shoulder pain and numbness down the left arm and severe neck pain. Objective findings on exam revealed limited range of motion with guarding of paracervical muscle. There is tenderness over the anterior left shoulder and about the A/C joint. There is decreased sensation into the ulnar to the fingers in bilateral hands. She is diagnosed with left shoulder impingement. She has been recommended for enhanced MRI of the spine and EMG/NCV of the upper extremities due to increased sensation in the left right and small finger with weakness in the right hand. Prior utilization review dated 05/14/2014 states the request for Repeat Electromyogram (EMG) (site not provided) is denied as medical necessity has not been established.

IMR ISSUES, DECISIONS AND RATIONALES

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

Repeat Electromyogram (EMG) (site not provided): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 176.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Neuromuscular electrical stimulation (NMES devices), Electromyogram.

Decision rationale: According to the Chronic Pain Medical Treatment Guideline, Electromyography (EMG) - triggered electrical stimulation therapy appears to be useful in a supervised physical therapy setting to rehabilitate atrophied upper extremity muscles following a stroke and as part of a comprehensive physical therapy program. In this case, there is a lack of supporting documentation thus fore, it is not medically necessary at this time.