

Case Number:	CM15-0142543		
Date Assigned:	08/03/2015	Date of Injury:	01/22/2015
Decision Date:	09/22/2015	UR Denial Date:	06/26/2015
Priority:	Standard	Application Received:	07/22/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 33 year old female, who sustained an industrial injury on 01-22-2015 secondary to being electrocuted while cleaning resulting in immediate pain in chest, arms, hands right arm and hand. On provider visit dated 06-11-2015 the injured worker has reported improving pain in shoulder, elbow, wrist and hand on the right side. On examination the range of motion on elevation of the right upper extremity was noted. Improved range of motion was noted on flexion and extension of the right elbow and wrist on the right side. The diagnoses have included shoulder impingement, elbow tendinitis and wrist tendinitis and bursitis. Treatment to date has included physical therapy and medication. The provider requested electromyogram of left and right upper extremity and nerve conduction velocity of left and right upper extremity.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG left upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007), Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

Decision rationale: ACOEM guidelines support ordering of imaging studies for emergence of red flags, 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. Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear, however, 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. Per MTUS ACOEM p182, with regard to the detection of neurologic abnormalities, EMG for diagnosis of nerve root involvement if findings of history, physical exam, and imaging study are consistent, is not recommended. Per progress report dated 6/11/15, the injured worker reported improving pain in shoulder, elbow, wrist, and hand on the right side. Per physical examination, improved range of motion was noted on flexion and extension of the right elbow and wrist on the right side. Diagnoses included shoulder impingement, elbow tendinitis, and wrist tendinitis and bursitis. Per note dated 3/17/15, it was noted that the injured worker previously was seen at by an industrial clinic, EKG and EMG were conducted, and she received medical therapy. EMG results were not available for review. Per 3/17/15 note, the injured worker complained of right upper extremity pain with weakness in elbow flexion and in grip. Decreased two-point discrimination was noted over the right hand. The clinical documentation does not present any neurologic findings related to the left upper extremity, as such, the request is not medically necessary.

NCV left upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 10 Elbow Disorders (Revised 2007), Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Nerve conduction studies (NCS).

Decision rationale: Per the ODG guidelines with regard to NCS: Not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. (Utah, 2006) This systematic review and meta-analysis demonstrate that neurological testing procedures have limited overall diagnostic accuracy in detecting disc herniation with suspected radiculopathy. (Al Nezari, 2013) In the management of spine trauma with radicular symptoms, EMG/nerve conduction studies (NCS) often have low combined sensitivity and specificity in confirming root injury, and there is limited evidence to support the use of often uncomfortable and costly EMG/NCS. (Charles,

2013) See also the Carpal Tunnel Syndrome Chapter for more details on NCS. Studies have not shown portable nerve conduction devices to be effective. EMGs (electromyography) are 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. As the requested treatment is not recommended, the request is not medically necessary.

NCV right upper extremity: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 10 Elbow Disorders (Revised 2007), Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Nerve conduction studies (NCS).

Decision rationale: Per the ODG guidelines with regard to NCS: Not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. (Utah, 2006) This systematic review and meta-analysis demonstrate that neurological testing procedures have limited overall diagnostic accuracy in detecting disc herniation with suspected radiculopathy. (Al Nezari, 2013) In the management of spine trauma with radicular symptoms, EMG/nerve conduction studies (NCS) often have low combined sensitivity and specificity in confirming root injury, and there is limited evidence to support the use of often uncomfortable and costly EMG/NCS. (Charles, 2013) See also the Carpal Tunnel Syndrome Chapter for more details on NCS. Studies have not shown portable nerve conduction devices to be effective. EMGs (electromyography) are 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. As there is no presumption of symptoms on the basis of radiculopathy, rather, in this case the injured worker was electrocuted, the request is medically necessary.

EMG right upper extremity: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 10 Elbow Disorders (Revised 2007), Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints
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Decision rationale: ACOEM guidelines support ordering of imaging studies for emergence of red flags, 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. Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal

findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear, however, 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. Per MTUS ACOEM p182, with regard to the detection of neurologic abnormalities, EMG for diagnosis of nerve root involvement if findings of history, physical exam, and imaging study are consistent, is not recommended. Per progress report dated 6/11/15, the injured worker reported improving pain in shoulder, elbow, wrist, and hand on the right side. Per physical examination, improved range of motion was noted on flexion and extension of the right elbow and wrist on the right side. Diagnoses included shoulder impingement, elbow tendinitis, and wrist tendinitis and bursitis. Per note dated 3/17/15, it was noted that the injured worker previously was seen at by an industrial clinic, EKG and EMG were conducted, and she received medical therapy. EMG results were not available for review. Per 3/17/15 note, the injured worker complained of right upper extremity pain with weakness in elbow flexion and in grip. Decreased two-point discrimination was noted over the right hand. I respectfully disagree with the UR physician's assertion that the documentation had no indication of peripheral nerve impingement. The request is medically necessary.