

<b>Case Number:</b>	CM15-0219755		
<b>Date Assigned:</b>	11/12/2015	<b>Date of Injury:</b>	02/12/2010
<b>Decision Date:</b>	12/22/2015	<b>UR Denial Date:</b>	11/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/09/2015

### 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: North Carolina

Certification(s)/Specialty: Family Practice

### 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 45 year old male who sustained an industrial injury on 02-12-2010. A review of the medical records indicated that the injured worker is undergoing treatment for right shoulder dislocation, right shoulder adhesive capsulitis, right rotator cuff arthropathy, right knee arthralgia and right foot fracture. The injured worker is status post closed manipulation of right shoulder dislocation with intravenous sedation on 02-12-2010, right shoulder surgery and labrum repair (2011-2012) and right shoulder revision with subacromial decompression, Mumford procedure and rotator cuff repair on 06-09-2014. According to the treating physician's progress report on 08-27-2015, the injured worker continues to experience right shoulder pain with a clicking and grinding sensation radiating to his hands, fingers and neck, right knee pain with buckling, giving way and swelling, right ankle pain and swelling and right foot pain radiating to the toes associated with numbness and tingling and swelling. The examination of the right shoulder demonstrated diffuse tenderness with decreased and painful range of motion. A slight positive impingement test was noted without instability and negative Hawkins. The right knee was non-tender with no joint line tenderness and negative patella compression, anterior-posterior drawer and pivot shift tests. Range of motion was 0-135 degrees. Examination of the right ankle demonstrated tenderness laterally without swelling and dorsiflexion to 10 degrees and plantar flexion to 30 degrees which was equal bilaterally and no limitation of inversion and eversion. X-rays of the right shoulder, right knee, tibia and fibula were interpreted within the progress note dated 08-27-2015. Prior treatments have included diagnostic testing, surgery, chiropractic therapy, physical therapy, acupuncture therapy, psychological evaluation and medications.

Current medications were listed as Tylenol #3 and Omeprazole. Treatment plan consists of the current request for a neurology consultation, Electromyography (EMG) and Nerve Conduction Velocity (NCV) studies of the bilateral upper extremities and Electromyography (EMG) and Nerve Conduction Velocity (NCV) studies of the bilateral lower extremities. On 11-03-2015 the Utilization Review determined the requests for a neurology consultation, Electromyography (EMG) and Nerve Conduction Velocity (NCV) studies of the bilateral upper extremities and Electromyography (EMG) and Nerve Conduction Velocity (NCV) studies of the bilateral lower extremities were not medically necessary.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Referral to Neurologist:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS General Approaches 2004, Section(s): General Approach to Initial Assessment and Documentation, Initial Approaches to Treatment.

**Decision rationale:** Per the ACOEM: The health practitioner may refer to other specialist if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A referral may be for 1. Consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability. The patient does have continued and ongoing peripheral neuropathy complaints despite conservative therapy. Therefore consult with a neurologist is medically warranted and the request is certified. Therefore, the requested treatment is medically necessary.

**EMG (Electromyography)/ NCS (Nerve Conduction Study) of the upper extremities:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies.

**Decision rationale:** The ACOEM chapter on neck and upper back complaints and special diagnostic studies states: 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. 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. The assessment may include sensory evoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected. If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps, including the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, compute tomography [CT] for bony structures). Additional studies may be considered to further define problem areas. The recent evidence indicates cervical disk annular tears may be missed on MRIs. The clinical significance of such a finding is unclear, as it may not correlate temporally or anatomically with symptoms. The provided documentation does not show any signs of emergence of red flags. There is evidence of neurologic dysfunction on exam. There is no mention of planned invasive procedures. There are no subtle neurologic findings listed on the physical exam. Conservative treatment has not been exhausted. For these reasons criteria for special diagnostic testing has not been met per the ACOEM. Therefore the request is not medically necessary.

**EMG (Electromyelography)/ NCS (Nerve Conduction Study) of the lower extremities:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004,  
Section(s): Special Studies.

**Decision rationale:** The ACOEM chapters on low back complaints and the need for lower extremity EMG/NCV states: Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures). Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. In this patient's case the progress notes are hand written and the exact objective findings are unclear. There is no objective evidence of neurologic dysfunction or unequivocal objective findings that identify nerve compromise as documented in the provided physical exam. For these reasons, criteria for lower extremity EMG/NCV have not been met as set forth in the ACOEM. Therefore the request is not certified. Therefore, the requested treatment is not medically necessary.