

<b>Case Number:</b>	CM15-0046251		
<b>Date Assigned:</b>	03/18/2015	<b>Date of Injury:</b>	01/24/2013
<b>Decision Date:</b>	04/24/2015	<b>UR Denial Date:</b>	02/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/11/2015

### 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: Pennsylvania

Certification(s)/Specialty: Internal Medicine

### 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 34 year old male who sustained an industrial injury on 01/24/2013. He has reported injury to the left shoulder. The diagnoses have included left shoulder sprain/strain; left shoulder joint pain; and status post surgery left shoulder. Treatment to date has included medications, physical therapy, and surgical intervention. MRI of the left shoulder with arthrogram on 12/19/14 showed flat and laterally downsloping acromion, osteoarthritis of the acromioclavicular joint, supraspinatus tendinosis, partial thickness tear of the infraspinatus, synovial effusion, subacromial/subdeltoid and subcoracoid bursitis, and subcortical cysts in the humeral head. At a visit on 12/11/14, the injured worker complained of left shoulder pain and stiffness, and numbness and weakness in the left upper extremity. Examination of the left shoulder showed decreased range of motion, tenderness of the acromioclavicular joint and anterior shoulder, pain with Neers test, and 4/5 strength of the left supraspinatus. Work status was full duty without restrictions. A progress note from the treating physician, dated 01/22/2015, documented that the injured worker continued to complain of intermittent moderate left shoulder pain and stiffness, associated with pushing, pulling repetitively, and overhead reaching. Examination was unchanged. The treatment plan has included acupuncture, orthopedic surgical consultation, and electromyography (EMG)/nerve conduction velocity (NCV) studies of the upper extremities. On 2/4/15, Utilization Review (UR) denied requests for EMG left upper extremity, NCV right upper extremity, NCV left upper extremity, and EMG right upper extremity, citing the MTUS.

## **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 8 Neck and Upper Back Complaints, 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 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 182, 268-269, 272. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck and upper back chapter: EMG, nerve conduction studies.

**Decision rationale:** This injured worker had shoulder pain and tenderness with numbness and weakness of the left upper extremity. He had undergone prior shoulder surgery, and had a recent MRI with findings as noted including arthritis, supraspinatus tendinosis, tear of the infraspinatus, and bursitis. The treating physician ordered EMG/NCV of bilateral upper extremities. The MTUS/ACOEM and ODG do not address EMG/NCV in relation to shoulder disorders. The ACOEM recommends EMG (electromyogram) to clarify nerve root dysfunction in cases of suspected disk herniation preoperatively or before epidural steroid injection. Nerve conduction velocity (NCV) is recommended for median or ulnar impingement at the wrist after failure of conservative treatment. The ODG notes that EMG is moderately sensitive in relation to cervical radiculopathy. Nerve conduction studies are not recommended to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but recommended if the EMG does not clearly demonstrate radiculopathy or is 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 minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy. While cervical electrodiagnostic studies are not necessary to demonstrate a cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality, diabetic neuropathy, or some problem other than a cervical radiculopathy, with caution that these studies can result in unnecessary over treatment. In this case, there was no documentation of suspicion of disc herniation, cervical radiculopathy, or median or ulnar nerve impingement at the wrist. No examination of the neck was documented. There was no detailed neurologic examination, including detailed motor/sensor exam and reflexes of the upper extremities. The examination showed decreased strength on examination of the supraspinatus, with finding on MRI of supraspinatus tendinosis. The injured worker reported numbness in the left upper extremity but this was not more specifically discussed as related to any particular dermatome, and no sensory examination of the upper extremities was documented. No complaints or findings related to the right upper extremity were documented. Due to lack of indication per the criteria outlined in the guidelines, the request for EMG of the left upper extremity is not medically necessary.

**NCV right upper extremity:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, 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 11 Forearm, Wrist, and Hand Complaints, Chapter 8 Neck and Upper Back Complaints Page(s): 182, 268-269, 272. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck and upper back chapter: EMG, nerve conduction studies.

**Decision rationale:** This injured worker had shoulder pain and tenderness with numbness and weakness of the left upper extremity. He had undergone prior shoulder surgery, and had a recent MRI with findings as noted including arthritis, supraspinatus tendinosis, tear of the infraspinatus, and bursitis. The treating physician ordered EMG/NCV of bilateral upper extremities. The MTUS/ACOEM and ODG do not address EMG/NCV in relation to shoulder disorders. The ACOEM recommends EMG (electromyogram) to clarify nerve root dysfunction in cases of suspected disk herniation preoperatively or before epidural steroid injection. Nerve conduction velocity (NCV) is recommended for median or ulnar impingement at the wrist after failure of conservative treatment. The ODG notes that EMG is moderately sensitive in relation to cervical radiculopathy. Nerve conduction studies are not recommended to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but recommended if the EMG does not clearly demonstrate radiculopathy or is 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 minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy. While cervical electrodiagnostic studies are not necessary to demonstrate a cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality, diabetic neuropathy, or some problem other than a cervical radiculopathy, with caution that these studies can result in unnecessary over treatment. In this case, there was no documentation of suspicion of disc herniation, cervical radiculopathy, or median or ulnar nerve impingement at the wrist. No examination of the neck was documented. There was no detailed neurologic examination, including detailed motor/sensor exam and reflexes of the upper extremities. The examination showed decreased strength on examination of the supraspinatus, with finding on MRI of supraspinatus tendinosis. The injured worker reported numbness in the left upper extremity but this was not more specifically discussed as related to any particular dermatome, and no sensory examination of the upper extremities was documented. No complaints or findings related to the right upper extremity were documented. Due to lack of indication per the criteria outlined in the guidelines, the request for NCV of the right upper extremity is not medically necessary.

**NCV left upper extremity:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, 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 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 182, 268-269, 272. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck and upper back chapter: EMG, nerve conduction studies.

**Decision rationale:** This injured worker had shoulder pain and tenderness with numbness and weakness of the left upper extremity. He had undergone prior shoulder surgery, and had a recent MRI with findings as noted including arthritis, supraspinatus tendinosis, tear of the infraspinatus, and bursitis. The treating physician ordered EMG/NCV of bilateral upper extremities. The MTUS/ACOEM and ODG do not address EMG/NCV in relation to shoulder disorders. The ACOEM recommends EMG (electromyogram) to clarify nerve root dysfunction in cases of suspected disk herniation preoperatively or before epidural steroid injection. Nerve conduction velocity (NCV) is recommended for median or ulnar impingement at the wrist after failure of conservative treatment. The ODG notes that EMG is moderately sensitive in relation to cervical radiculopathy. Nerve conduction studies are not recommended to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but recommended if the EMG does not clearly demonstrate radiculopathy or is 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 minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy. While cervical electrodiagnostic studies are not necessary to demonstrate a cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality, diabetic neuropathy, or some problem other than a cervical radiculopathy, with caution that these studies can result in unnecessary over treatment. In this case, there was no documentation of suspicion of disc herniation, cervical radiculopathy, or median or ulnar nerve impingement at the wrist. No examination of the neck was documented. There was no detailed neurologic examination, including detailed motor/sensor exam and reflexes of the upper extremities. The examination showed decreased strength on examination of the supraspinatus, with finding on MRI of supraspinatus tendinosis. The injured worker reported numbness in the left upper extremity but this was not more specifically discussed as related to any particular dermatome, and no sensory examination of the upper extremities was documented. No complaints or findings related to the right upper extremity were documented. Due to lack of indication per the criteria outlined in the guidelines, the request for NCV of the left upper extremity is not medically necessary.

**EMG right upper extremity:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 10 Elbow Disorders (Revised 2007), Chapter 11 Forearm, Wrist, and Hand Complaints.

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**Decision rationale:** This injured worker had shoulder pain and tenderness with numbness and weakness of the left upper extremity. He had undergone prior shoulder surgery, and had a recent MRI with findings as noted including arthritis, supraspinatus tendinosis, tear of the infraspinatus, and bursitis. The treating physician ordered EMG/NCV of bilateral upper extremities. The MTUS/ACOEM and ODG do not address EMG/NCV in relation to shoulder disorders. The ACOEM recommends EMG (electromyogram) to clarify nerve root dysfunction in cases of suspected disk herniation preoperatively or before epidural steroid injection. Nerve conduction velocity (NCV) is recommended for median or ulnar impingement at the wrist after failure of conservative treatment. The ODG notes that EMG is moderately sensitive in relation to cervical radiculopathy. Nerve conduction studies are not recommended to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but recommended if the EMG does not clearly demonstrate radiculopathy or is 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 minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy. While cervical electrodiagnostic studies are not necessary to demonstrate a cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality, diabetic neuropathy, or some problem other than a cervical radiculopathy, with caution that these studies can result in unnecessary over treatment. In this case, there was no documentation of suspicion of disc herniation, cervical radiculopathy, or median or ulnar nerve impingement at the wrist. No examination of the neck was documented. There was no detailed neurologic examination, including detailed motor/sensor exam and reflexes of the upper extremities. The examination showed decreased strength on examination of the supraspinatus, with finding on MRI of supraspinatus tendinosis. The injured worker reported numbness in the left upper extremity but this was not more specifically discussed as related to any particular dermatome, and no sensory examination of the upper extremities was documented. No complaints or findings related to the right upper extremity were documented. Due to lack of indication per the criteria outlined in the guidelines, the request for EMG of the right upper extremity is not medically necessary.