

Case Number:	CM15-0067144		
Date Assigned:	04/14/2015	Date of Injury:	06/28/2011
Decision Date:	07/01/2015	UR Denial Date:	04/01/2015
Priority:	Standard	Application Received:	04/08/2015

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

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 56 year old female, who sustained an industrial injury on June 28, 2011, incurring injuries to the wrists, arms, right shoulder, neck and low back from repetitive use. She was diagnosed with right tendonitis, lumbar sprain, arm strain and cervical spine strain. Treatment included physical therapy, home exercise program, anti-inflammatory drugs, epidural steroid injection, acupuncture, cortisone injections, chiropractic sessions and massage therapy. Currently, the injured worker complained persistent shoulder pain and neck pain. The treatment plan that was requested for authorization included a left wrist Electromyography, right wrist Electromyography, left wrist Nerve Conduction Velocity and a right wrist Nerve Conduction Velocity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left wrist EMG: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178, 181-183. Decision based on Non-MTUS Citation Official

Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic) Nerve conduction studies (NCS). Work Loss Data Institute <http://www.guideline.gov/content.aspx?id=47589>.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses nerve conduction studies (NCS). American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 8 Neck and Upper Back Complaints (Page 178) states that nerve conduction velocities (NCV) may help identify subtle focal neurologic dysfunction. Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic) indicates that nerve conduction studies (NCS) are not recommended to demonstrate radiculopathy. MTUS addresses EMG electromyography. ACOEM 2nd Edition (2004) Chapter 8 Neck and Upper Back Complaints Table 8-8 Summary of Recommendations for Evaluating and Managing Neck and Upper Back Complaints (Page 181-183) indicates that EMG electromyography for diagnosis of nerve involvement, if findings of history, physical exam, and imaging study are consistent, is not recommended. Electromyography (EMG) may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. Work Loss Data Institute guidelines for the neck and upper back (acute & chronic) indicates that EMG is not necessary for the diagnosis of intervertebral disk disease with radiculopathy. The EMG / Nerve conduction study report dated 4/5/12 documented normal right median nerve both motor and sensory components, normal right ulnar nerve both motor and sensory components, normal left median nerve both motor and sensory components, and normal left ulnar nerve both motor and sensory component. The NCS of the bilateral median and ulnar nerves is normal. There is no evidence of a focal neuropathic process involving these nerves. X-ray dated 12/16/11 demonstrated left mild carpometacarpal first osteoarthritis. The treating physician's permanent and stationary report dated December 2, 2014 documented the diagnoses of cervical strain, degenerative disc disease of the lumbar spine, left shoulder impingement syndrome, and status post left shoulder arthroscopy with decompression 3/14/14. The treating physician found that the patient had reached a point of maximum medical improvement. The primary treating physician's progress report dated March 16, 2015 documented that the patient underwent the left shoulder arthroscopic subacromial decompression in March 2014. She had physical therapy and continues doing her home exercise program. She reports 30% of the symptoms improvement. The neck pain basically remains the same. She describes the pain as constant, dull and sharp, and averages a 7 on a scale from one to ten in intensity. The pain radiates to her arms, left greater than right. She reports numbness or tingling in her hands and thumbs. Physical examination demonstrated that there is strengthening of the cervical lordosis. Neck range of motion is limited to extension and lateral bending. Pain along facet joints and cervical paraspinal muscles was noted. Neck rotation is painful. Motor exam is normal throughout the bilateral lower and upper limbs muscles, except the left rotator cuff muscles, where strength is 4/5. Deep tendon reflexes are 2+ and symmetric at biceps, triceps, brachioradialis, and 2+ at knees and ankles. There is decreased sensation to pin prick along the left C6-7 level of dermatomal distribution. There is moderately severe pain at the base of both thumbs that increases with internal rotation. Diagnoses were cervical degenerative disc disease, cervical disc bulge, status post left shoulder arthroscopic surgery, first carpometacarpal arthritis. EMG/NCS of the bilateral upper extremities was requested. The EMG / Nerve conduction study report dated 2/14/13 documented normal right median nerve both motor and sensory components, normal right ulnar nerve both motor and sensory components, normal left median nerve both motor and sensory components, and normal left ulnar nerve both motor and sensory component. The NCS of the bilateral median and ulnar nerves is normal. There is no evidence of a focal neuropathic process involving these nerves, such as carpal tunnel or cubital tunnel syndrome. The patient has a history of cervical strain, left shoulder impingement syndrome, cervical degenerative disc disease, cervical disc bulge, first carpometacarpal arthritis, and status post left shoulder arthroscopy with decompression 3/14/14. The primary treating physician's

progress report dated March 16, 2015 documented neck pain that radiates into bilateral upper extremities. Motor exam is normal throughout the bilateral lower and upper limbs muscles, except the left rotator cuff muscles, where strength is 4/5, status post left shoulder arthroscopic subacromial decompression. Deep tendon reflexes are 2+ and symmetric at biceps, triceps, brachioradialis, and 2+ at knees and ankles. There is decreased sensation to pin prick along the left C6-7 level of dermatomal distribution. Two EMG / nerve conduction study reports dated 4/5/12 and 2/14/13 were normal. Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic) indicates that nerve conduction studies (NCS) are not recommended to demonstrate radiculopathy. Work Loss Data Institute guidelines for the neck and upper back (acute & chronic) indicates that EMG is not necessary for the diagnosis of intervertebral disk disease with radiculopathy. The primary treating physician's progress report dated March 16, 2015 does not present a discussion supporting the medical necessity of repeat electrodiagnostic studies of bilateral upper extremities. The request for repeat electrodiagnostic studies of bilateral upper extremities is not supported by clinical practice guidelines. Therefore, the request for left wrist EMG is not medically necessary.

Right wrist EMG: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178, 181-183. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic) Nerve conduction studies (NCS). Work Loss Data Institute <http://www.guideline.gov/content.aspx?id=47589>.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses nerve conduction studies (NCS). American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 8 Neck and Upper Back Complaints (Page 178) states that nerve conduction velocities (NCV) may help identify subtle focal neurologic dysfunction. Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic) indicates that nerve conduction studies (NCS) are not recommended to demonstrate radiculopathy. MTUS addresses EMG electromyography. ACOEM 2nd Edition (2004) Chapter 8 Neck and Upper Back Complaints Table 8-8 Summary of Recommendations for Evaluating and Managing Neck and Upper Back Complaints (Page 181-183) indicates that EMG electromyography for diagnosis of nerve involvement, if findings of history, physical exam, and imaging study are consistent, is not recommended. Electromyography (EMG) may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. Work Loss Data Institute guidelines for the neck and upper back (acute & chronic) indicates that EMG is not necessary for the diagnosis of intervertebral disk disease with radiculopathy. The EMG / Nerve conduction study report dated 4/5/12 documented normal right median nerve both motor and sensory components, normal right ulnar nerve both motor and sensory components, normal left median nerve both motor and sensory components, and normal left ulnar nerve both motor and sensory component. The NCS of the bilateral median and ulnar nerves is normal. There is no evidence of a focal neuropathic process involving these nerves. X-ray dated 12/16/11 demonstrated left mild carpometacarpal first osteoarthritis. The treating physician's permanent and stationary report dated December 2, 2014 documented the diagnoses of cervical strain, degenerative disc disease of the lumbar spine, left shoulder impingement syndrome, and status post left shoulder arthroscopy with decompression 3/14/14. The treating physician found that the patient had reached a point of maximum medical improvement. The

primary treating physician's progress report dated March 16, 2015 documented that the patient underwent the left shoulder arthroscopic subacromial decompression in March 2014. She had physical therapy and continues doing her home exercise program. She reports 30% of the symptoms improvement. The neck pain basically remains the same. She describes the pain as constant, dull and sharp, and averages a 7 on a scale from one to ten in intensity. The pain radiates to her arms, left greater than right. She reports numbness or tingling in her hands and thumbs. Physical examination demonstrated that there is strengthening of the cervical lordosis. Neck range of motion is limited to extension and lateral bending. Pain along facet joints and cervical paraspinal muscles was noted. Neck rotation is painful. Motor exam is normal throughout the bilateral lower and upper limbs muscles, except the left rotator cuff muscles, where strength is 4/5. Deep tendon reflexes are 2+ and symmetric at biceps, triceps, brachioradialis, and 2+ at knees and ankles. There is decreased sensation to pin prick along the left C6-7 level of dermatomal distribution. There is moderately severe pain at the base of both thumbs that increases with internal rotation. Diagnoses were cervical degenerative disc disease, cervical disc bulge, status post left shoulder arthroscopic surgery, first carpometacarpal arthritis. EMG/NCS of the bilateral upper extremities was requested. The EMG / Nerve conduction study report dated 2/14/13 documented normal right median nerve both motor and sensory components, normal right ulnar nerve both motor and sensory components, normal left median nerve both motor and sensory components, and normal left ulnar nerve both motor and sensory component. The NCS of the bilateral median and ulnar nerves is normal. There is no evidence of a focal neuropathic process involving these nerves, such as carpal tunnel or cubital tunnel syndrome. The patient has a history of cervical strain, left shoulder impingement syndrome, cervical degenerative disc disease, cervical disc bulge, first carpometacarpal arthritis, and status post left shoulder arthroscopy with decompression 3/14/14. The primary treating physician's progress report dated March 16, 2015 documented neck pain that radiates into bilateral upper extremities. Motor exam is normal throughout the bilateral lower and upper limbs muscles, except the left rotator cuff muscles, where strength is 4/5, status post left shoulder arthroscopic subacromial decompression. Deep tendon reflexes are 2+ and symmetric at biceps, triceps, brachioradialis, and 2+ at knees and ankles. There is decreased sensation to pin prick along the left C6-7 level of dermatomal distribution. Two EMG / nerve conduction study reports dated 4/5/12 and 2/14/13 were normal. Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic) indicates that nerve conduction studies (NCS) are not recommended to demonstrate radiculopathy. Work Loss Data Institute guidelines for the neck and upper back (acute & chronic) indicates that EMG is not necessary for the diagnosis of intervertebral disk disease with radiculopathy. The primary treating physician's progress report dated March 16, 2015 does not present a discussion supporting the medical necessity of repeat electrodiagnostic studies of bilateral upper extremities. The request for repeat electrodiagnostic studies of bilateral upper extremities is not supported by clinical practice guidelines. Therefore, the request for right wrist EMG is not medically necessary.

Left wrist NCS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178, 181-183. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic) Nerve conduction studies (NCS). Work Loss Data Institute <http://www.guideline.gov/content.aspx?id=47589>.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses nerve conduction studies (NCS). American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 8 Neck and Upper Back Complaints (Page 178) states that nerve conduction velocities (NCV) may help identify subtle focal neurologic dysfunction. Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic) indicates that nerve conduction studies (NCS) are not recommended to demonstrate radiculopathy. MTUS addresses EMG electromyography. ACOEM 2nd Edition (2004) Chapter 8 Neck and Upper Back Complaints Table 8-8 Summary of Recommendations for Evaluating and Managing Neck and Upper Back Complaints (Page 181-183) indicates that EMG electromyography for diagnosis of nerve involvement, if findings of history, physical exam, and imaging study are consistent, is not recommended. Electromyography (EMG) may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. Work Loss Data Institute guidelines for the neck and upper back (acute & chronic) indicates that EMG is not necessary for the diagnosis of intervertebral disk disease with radiculopathy. The EMG / Nerve conduction study report dated 4/5/12 documented normal right median nerve both motor and sensory components, normal right ulnar nerve both motor and sensory components, normal left median nerve both motor and sensory components, and normal left ulnar nerve both motor and sensory component. The NCS of the bilateral median and ulnar nerves is normal. There is no evidence of a focal neuropathic process involving these nerves. X-ray dated 12/16/11 demonstrated left mild carpometacarpal first osteoarthritis. The treating physician's permanent and stationary report dated December 2, 2014 documented the diagnoses of cervical strain, degenerative disc disease of the lumbar spine, left shoulder impingement syndrome, and status post left shoulder arthroscopy with decompression 3/14/14. The treating physician found that the patient had reached a point of maximum medical improvement. The primary treating physician's progress report dated March 16, 2015 documented that the patient underwent the left shoulder arthroscopic subacromial decompression in March 2014. She had physical therapy and continues doing her home exercise program. She reports 30% of the symptoms improvement. The neck pain basically remains the same. She describes the pain as constant, dull and sharp, and averages a 7 on a scale from one to ten in intensity. The pain radiates to her arms, left greater than right. She reports numbness or tingling in her hands and thumbs. Physical examination demonstrated that there is strengthening of the cervical lordosis. Neck range of motion is limited to extension and lateral bending. Pain along facet joints and cervical paraspinal muscles was noted. Neck rotation is painful. Motor exam is normal throughout the bilateral lower and upper limbs muscles, except the left rotator cuff muscles, where strength is 4/5. Deep tendon reflexes are 2+ and symmetric at biceps, triceps, brachioradialis, and 2+ at knees and ankles. There is decreased sensation to pin prick along the left C6-7 level of dermatomal distribution. There is moderately severe pain at the base of both thumbs that increases with internal rotation. Diagnoses were cervical degenerative disc disease, cervical disc bulge, status post left shoulder arthroscopic surgery, first carpometacarpal arthritis. EMG/NCS of the bilateral upper extremities was requested. The EMG / Nerve conduction study report dated 2/14/13 documented normal right median nerve both motor and sensory components, normal right ulnar nerve both motor and sensory components, normal left median nerve both motor and sensory components, and normal left ulnar nerve both motor and sensory component. The NCS of the bilateral median and ulnar nerves is normal. There is no evidence of a focal neuropathic process involving these nerves, such as carpal tunnel or cubital tunnel syndrome. The patient has a history of cervical strain, left shoulder impingement syndrome, cervical degenerative disc disease, cervical disc bulge, first carpometacarpal arthritis, and status post left shoulder arthroscopy with decompression 3/14/14. The primary treating physician's progress report dated March 16, 2015 documented neck pain that radiates into bilateral upper extremities. Motor exam is normal throughout the bilateral lower and upper limbs muscles, except the left rotator cuff muscles, where strength is 4/5, status post left shoulder arthroscopic

subacromial decompression. Deep tendon reflexes are 2+ and symmetric at biceps, triceps, brachioradialis, and 2+ at knees and ankles. There is decreased sensation to pin prick along the left C6-7 level of dermatomal distribution. Two EMG / nerve conduction study reports dated 4/5/12 and 2/14/13 were normal. Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic) indicates that nerve conduction studies (NCS) are not recommended to demonstrate radiculopathy. Work Loss Data Institute guidelines for the neck and upper back (acute & chronic) indicates that EMG is not necessary for the diagnosis of intervertebral disk disease with radiculopathy. The primary treating physician's progress report dated March 16, 2015 does not present a discussion supporting the medical necessity of repeat electrodiagnostic studies of bilateral upper extremities. The request for repeat electrodiagnostic studies of bilateral upper extremities is not supported by clinical practice guidelines. Therefore, the request for left wrist NCS is not medically necessary.

Right wrist NCS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178, 181-183. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic) Nerve conduction studies (NCS). Work Loss Data Institute <http://www.guideline.gov/content.aspx?id=47589>.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses nerve conduction studies (NCS). American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 8 Neck and Upper Back Complaints (Page 178) states that nerve conduction velocities (NCV) may help identify subtle focal neurologic dysfunction. Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic) indicates that nerve conduction studies (NCS) are not recommended to demonstrate radiculopathy. MTUS addresses EMG electromyography. ACOEM 2nd Edition (2004) Chapter 8 Neck and Upper Back Complaints Table 8-8 Summary of Recommendations for Evaluating and Managing Neck and Upper Back Complaints (Page 181-183) indicates that EMG electromyography for diagnosis of nerve involvement, if findings of history, physical exam, and imaging study are consistent, is not recommended. Electromyography (EMG) may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. Work Loss Data Institute guidelines for the neck and upper back (acute & chronic) indicates that EMG is not necessary for the diagnosis of intervertebral disk disease with radiculopathy. The EMG / Nerve conduction study report dated 4/5/12 documented normal right median nerve both motor and sensory components, normal right ulnar nerve both motor and sensory components, normal left median nerve both motor and sensory components, and normal left ulnar nerve both motor and sensory component. The NCS of the bilateral median and ulnar nerves is normal. There is no evidence of a focal neuropathic process involving these nerves. X-ray dated 12/16/11 demonstrated left mild carpometacarpal first osteoarthritis. The treating physician's permanent and stationary report dated December 2, 2014 documented the diagnoses of cervical strain, degenerative disc disease of the lumbar spine, left shoulder impingement syndrome, and status post left shoulder arthroscopy with decompression 3/14/14. The treating physician found that the patient had reached a point of maximum medical improvement. The primary treating physician's progress report dated March 16, 2015 documented that the patient underwent the left shoulder arthroscopic subacromial decompression in March 2014. She had physical therapy and continues doing her home exercise program. She reports 30% of the

symptoms improvement. The neck pain basically remains the same. She describes the pain as constant, dull and sharp, and averages a 7 on a scale from one to ten in intensity. The pain radiates to her arms, left greater than right. She reports numbness or tingling in her hands and thumbs. Physical examination demonstrated that there is strengthening of the cervical lordosis. Neck range of motion is limited to extension and lateral bending. Pain along facet joints and cervical paraspinal muscles was noted. Neck rotation is painful. Motor exam is normal throughout the bilateral lower and upper limbs muscles, except the left rotator cuff muscles, where strength is 4/5. Deep tendon reflexes are 2+ and symmetric at biceps, triceps, brachioradialis, and 2+ at knees and ankles. There is decreased sensation to pin prick along the left C6-7 level of dermatomal distribution. There is moderately severe pain at the base of both thumbs that increases with internal rotation. Diagnoses were cervical degenerative disc disease, cervical disc bulge, status post left shoulder arthroscopic surgery, first carpometacarpal arthritis. EMG/NCS of the bilateral upper extremities was requested. The EMG / Nerve conduction study report dated 2/14/13 documented normal right median nerve both motor and sensory components, normal right ulnar nerve both motor and sensory components, normal left median nerve both motor and sensory components, and normal left ulnar nerve both motor and sensory component. The NCS of the bilateral median and ulnar nerves is normal. There is no evidence of a focal neuropathic process involving these nerves, such as carpal tunnel or cubital tunnel syndrome. The patient has a history of cervical strain, left shoulder impingement syndrome, cervical degenerative disc disease, cervical disc bulge, first carpometacarpal arthritis, and status post left shoulder arthroscopy with decompression 3/14/14. The primary treating physician's progress report dated March 16, 2015 documented neck pain that radiates into bilateral upper extremities. Motor exam is normal throughout the bilateral lower and upper limbs muscles, except the left rotator cuff muscles, where strength is 4/5, status post left shoulder arthroscopic subacromial decompression. Deep tendon reflexes are 2+ and symmetric at biceps, triceps, brachioradialis, and 2+ at knees and ankles. There is decreased sensation to pin prick along the left C6-7 level of dermatomal distribution. Two EMG / nerve conduction study reports dated 4/5/12 and 2/14/13 were normal. Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic) indicates that nerve conduction studies (NCS) are not recommended to demonstrate radiculopathy. Work Loss Data Institute guidelines for the neck and upper back (acute & chronic) indicates that EMG is not necessary for the diagnosis of intervertebral disk disease with radiculopathy. The primary treating physician's progress report dated March 16, 2015 does not present a discussion supporting the medical necessity of repeat electrodiagnostic studies of bilateral upper extremities. The request for repeat electrodiagnostic studies of bilateral upper extremities is not supported by clinical practice guidelines. Therefore, the request for right wrist NCS is not medically necessary.