

Case Number:	CM14-0117467		
Date Assigned:	08/04/2014	Date of Injury:	11/05/2012
Decision Date:	10/08/2014	UR Denial Date:	06/11/2014
Priority:	Standard	Application Received:	07/24/2014

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 & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in California. 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 injured worker is a 57-year-old female who sustained an injury on 11/05/12. She complained of right shoulder, cervical, lumbar, and thoracic spine pain. On exam, there were positive impingement and Speed's tests. There was tenderness in the lumbar and cervical spine. Decreased range of motion (ROM) of cervical and lumbar spine was noted. On 01/07/14, impingement test was negative with negative Neer and Hawkins test. Strength was 4/5 in forward flexion and 5/5 in external and internal rotation. Sensation was normal. ROM of the right shoulder revealed extension was 30 degrees, internal and external rotation 60 degrees, abduction 160 degrees, and adduction 30 degrees. On 11/26/13, ROM of the right shoulder revealed flexion 100 degrees, internal and external rotation 40 degrees and abduction 100 degrees. She underwent a right shoulder arthroscopy with mini open rotator cuff repair on 04/20/13. Stiffness occurred post-surgery with manipulation under anesthesia recommended; he failed to present for manipulation on 2 occasions. Diagnoses include status post right shoulder surgery in 2012; C-spine and L-spine sprain/strain; bilateral shoulder pain, resolved; and right shoulder radiculopathy. As of 01/07/14 the patient has reached MMI; future care was recommended.

IMR ISSUES, DECISIONS AND RATIONALES

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

Muscle Test of 2 limbs- Electromyogram of the bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment in Workers Compensation

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain.

Decision rationale: Per ACOEM guidelines, appropriate electrodiagnostic studies may help differentiate between CTS and other conditions such as cervical radiculopathy. Electrodiagnostic studies may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms or both lasting more than three to four weeks. Needle EMG and not nerve conduction testing is what usually makes the diagnosis of radiculopathy. Needle EMG can help determine if radiculopathy is acute or chronic. Nerve conduction studies are usually normal in radiculopathy (except for motor nerve amplitude loss in muscles innervated by the involved nerve root in more severe radiculopathy). Nerve conduction studies rule out other causes for limb symptoms (generalized peripheral neuropathy, compression neuropathy) that can mimic radiculopathy. Indications are: Failure to resolve or plateau of suspected radicular pain without resolution after waiting 4 to 6 weeks (to provide for sufficient time to develop EMG abnormalities as well as time for conservative treatment to resolve the problems), equivocal imaging findings such as CT or MRI, and suspicion by history and physical examination that a neurologic condition other than radiculopathy may be present instead of or in addition to radiculopathy. According to the ODG, EMG's are not necessary if radiculopathy is already clinically obvious. In this case, there is no evidence of radicular symptoms such as pain, numbness or weakness in the upper extremities. There are no imaging studies with equivocal evidence to warrant a confirmation by Electrodiagnostic studies. There is no documentation of trial of conservative management such as physical therapy (PT) or NSAIDs. Therefore, the medical necessity of the request is not established per guidelines.

Muscle test of 2 limbs, Nerve Conduction Velocity of the bilateral upper extremities:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment in Workers Compensation

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), pain

Decision rationale: Per ACOEM guidelines, appropriate electrodiagnostic studies may help differentiate between CTS and other conditions such as cervical radiculopathy. Electrodiagnostic studies may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms or both lasting more than three to four weeks. Per ODG guidelines, "there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy." On the other hand, NCS is recommended to differentiate between radiculopathy and neuropathies. Furthermore, Nerve conduction studies are used to rule out peripheral neuropathy, or compression neuropathy that can mimic radiculopathy.

In this case, there is little to no evidence of neurological symptoms such as pain, numbness or weakness in the upper extremities, suggesting peripheral neuropathy or entrapment neuropathy. There is no documentation of trial of conservative management such as PT or NSAIDs. Therefore, the medical necessity of the request is not established per guidelines.