

Case Number:	CM14-0211345		
Date Assigned:	12/24/2014	Date of Injury:	05/09/2009
Decision Date:	02/20/2015	UR Denial Date:	12/04/2014
Priority:	Standard	Application Received:	12/17/2014

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. 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: Texas, California
 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:

This is a 51 year old female patient who sustained a work related injury on 5/9/09. The exact mechanism of injury was not specified in the records provided. The current diagnoses include discogenic lumbar condition with radicular component down the left lower extremity; impingement syndrome of the shoulder on the right; internal derangement of the knee; status post right shoulder surgery and anterior cruciate ligament (ACL) left knee surgery. Per the doctor's note dated 10/6/14, patient has complaints of pain in left knee, low back and the right shoulder. Physical examination revealed tenderness along the rotator cuff, abduction 90 degrees, negative drop arm test, weakness to resisted function. Per the doctor's note dated 8/5/14 patient had complaints of numbness and tingling in the right hand and the right thumb, right index and the right third digit. Physical examination revealed Neck flexion to 25 degrees and extension to 25 degrees. Right upper extremity laterally abducts to 65 degrees. The current medication lists include Norco, trazadone, Flexeril, tramadol and Lunesta. The patient has had MRI of the left knee that revealed patellofemoral compartment arthrosis including grade 2,3 chondromalacia patella and joint effusion; MRI of the shoulder that revealed small partial tears involving supraspinatus and infraspinatus tendons; MRI of the lumbar spine that revealed multilevel disc disease and right shoulder impingement. The patient's surgical history include right shoulder surgery on 11/21/13 and anterior cruciate ligament (ACL) left knee surgery on 9/29/09; Colonoscopy on 12/27/13. The patient has received an unspecified number of PT visits for this injury. The patient has used a TENS unit, hot and cold wrap.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG / NCS bilateral upper extremities: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

Decision rationale: Per ACOEM chapter 12 guidelines, "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." Per the ACOEM guidelines cited below, "For most patients presenting with true neck or upper back problems, special studies are not needed unless a three- or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out..... 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." Detailed history and duration of signs /symptoms of tingling and numbness was not specified in the records provided. A plan for an invasive procedure for the upper extremity was not specified in the records provided. The response of the symptoms to a period of rest and oral pharmacotherapy including NSAIDS, was not specified in the records provided. Any objective evidence of cervical spine red flags or physiological evidence of tissue insult or neurological dysfunction was not specified in the records provided. Patient has received an unspecified number of PT visits for this injury. The records submitted contain no accompanying current PT evaluation for this patient. A detailed response to a complete course of conservative therapy including PT visits was not specified in the records provided. Previous PT visit notes were not specified in the records provided. The medical necessity of the request for EMG / NCS bilateral upper extremities is not fully established for this patient.