

Case Number:	CM15-0013544		
Date Assigned:	02/02/2015	Date of Injury:	02/04/2011
Decision Date:	03/25/2015	UR Denial Date:	01/12/2015
Priority:	Standard	Application Received:	01/23/2015

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 (IW) is a 44 year old male who sustained an industrial injury on 02/04/2011. He has reported constant severe left shoulder pain and difficulty reaching above left shoulder. Pain is rated a 7-8 /10. The IW also reports stiffness and muscle spasm accompanied by shooting pains down the left arm with tingling, numbness and paresthesia. Pain often keeps him awake. The pain is exacerbated by cold and rainy weather. Diagnoses include left shoulder labral tear with SLAP (superior labral anterior posterior lesion) (MRI confirmed), status post left shoulder SLAP repair, right shoulder overuse syndrome, left cervical radiculitis, left carpal tunnel syndrome, and cervical sprain/strain. Treatments to date include left shoulder surgery, pain medications, and a home exercise program. In a progress note dated 01/05/2014 the treating provider reports a well healed long surgical scar and smaller well healed arthroscopic portals on the left shoulder. Range of movement of left shoulder is severely restricted, impingement test is positive. Localized tenderness is present at the AC joint. Nerve root compression is suspected. Treatment plans are for a needle EMG/NCV (electromyogram, nerve conduction velocity) study of upper extremities. On 01/12/2015 Utilization Review non-certified a request for 1 Needle EMG/Nerve Conduction Study of the Upper Extremities, noting the clinical information submitted for review fails to meet the evidence based guidelines for the requested service. The ACOEM Guidelines Chapter 8 Neck and Upper Back Complaints, and Official Disability Guidelines (ODG), Treatment Index, 11th Edition were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Needle EMG/Nerve Conduction Study of the Upper Extremities: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 11th Edition

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

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 tissue insult per the documented physical exam.. There is no mention of planned invasive procedures. There are no subtle neurologic findings listed on the physical exam. For these reasons criteria for special diagnostic testing has been based on the physical exam and evidence of neurologic dysfunction/tissue insult met per the ACOEM. Therefore the request is certified.