MAXIMUS Federal Services

Case Number:	CM13-0021148		
Date Assigned:	11/08/2013	Date of Injury:	09/10/2012
Decision Date:	09/19/2014	UR Denial Date:	08/26/2013
Priority:	Standard	Application Received:	09/06/2013

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 Internal Medicine and is licensed to practice in District of Columbia. 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:

[redacted] was a 60 year old female who had work related injury on 9/10/2012. She had reported right shoulder, arm and hand pain after repetitive work as a bank teller. She had no past medical history. She had history of gastric bypass, partial mastectomy and repair of umbilical hernia. Medications included Norco, Prozac and Muscle Relaxer. She was initially evaluated by her primary care physician and was diagnosed with tendinitis of the forearm and the biceps. She was prescribed Norco and was given cortisone injection in her shoulder. Her pain at the time of initial evaluation was sharp, burning, shooting over the entire right arm, worse with repetitive movements without significant numbness or tingling. She was diagnosed with bicipital tendinitis, De Quervain's tenosynovitis, medial epicondylitis during her visit in May 2013. She was referred to Physical therapy and continued on Norco for severe pain. During her visit to her treating provider in May 2013 and June 2013, she was noted to have normal sensation in bilateral upper extremities with normal strength and normal deep tendon reflexes. She was also noted to positive Neer's test, positive Hawkin's test and positive empty can test on right side. In addition she was noted during those visits to have negative Tinel's test and Phalen's test with positive Finkelstein's test. She was also noted to have normal neck range of motion. During her visit with the treating provider on August 07, 2013, she was noted to have constant, soreness type pain in the neck with popping and grinding. Her pain was noted to worsen with reading with her head down and was noted to radiate down to both shoulders. It was rated 8/10. She also had described bilateral shoulder pain with popping and grinding. Her pain radiated down to arms, elbows, wrists, hands and fingers. She reported that her arm fell asleep when she lied down on her side and when her arms were elevated on pillows with left side worse than the right side. She also described elbow pain bilaterally and wrist pain with popping. The pain worsened with manipulation and Physical therapy. She also reported constant pain in her hands. On examination, she had tenderness in

paraspinal cervical muscles, trapezii, acromium and lateral epicondyle. Her neck range of motion was full. Her bilateral shoulder movements were limited with decreased abduction, flexion and internal rotation. She was also noted to have bilateral positive Hawkin's test, Jobe's test, Finkelstein's maneuver, Phalen's test and postiive Tinel's sign. She had normal deep tendon reflexes, normal sensation, normal strength, normal muscle contour without atrophy in bilateral upper extremities. Her diagnoses included bilateral impingement syndrome of shoulders, bilateral lateral epicondylitis, bilateral De Quervain's stenosing tenosynovitis and bilateral carpal tunnel syndrome. Plan of care included anti-inflammatories and diagnostic studies including MRI of bilateral shoulders and EMG/NCS of bilateral upper extremities. MRI of right shoulder on 8/16/2013 showed moderate impingement, tendinosis of rotator cuff with a complete tear and fluid in the subdeltoid space. MRI of left shoulder on 8/16/2013 showed moderate impingement, tendinosis of rotator cuff with a partial tear beneath the acromion and fluid in the glenohumeral joint and subdeltoid bursa. Electrodiagnostic showed bilateral median neuropathy at the wrist.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG right upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 177-179, 271-273. 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): 178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck, Carpal tunnel syndrome, Electrodiagnostic studies.

Decision rationale: According to MTUS and the other evidences cited, EMG is recommended to evaluate for cervical radiculopathy. In this particular case, there is evidence of bilateral shoulder impingement syndrome and bilateral carpal tunnel syndrome. She was having symptoms despite activity modification and conservative therapy. There is no evidence of muscle wasting, hypoesthesia or focal deficits suggestive of cervical radiculopathy. There are no signs to suggest radiculopathy. Hence nerve conduction studies of bilateral upper extremities is medically necessary to evaluate the carpal tunnel syndrome given the worsening with physical therapy and rest. However EMG is not medically necessary while evaluating carpal tunnel syndrome with shoulder pathology not suspected to be due to cervical radiculopathy.

EMG left upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 177-179, 271-273. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain.

MAXIMUS 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 (ODG), Carpal tunnel syndrome and neck, electrodiagnostic studies.

Decision rationale: According to MTUS and the other evidences cited, EMG is recommended to evaluate for cervical radiculopathy. In this particular case, there is evidence of bilateral shoulder impingement syndrome and bilateral carpal tunnel syndrome. She was having symptoms despite activity modification and conservative therapy. There is no evidence of muscle wasting, hypoesthesia or focal deficits suggestive of cervical radiculopathy. There are no signs to suggest radiculopathy. Hence nerve conduction studies of bilateral upper extremities are medically necessary to evaluate the carpal tunnel syndrome given the worsening with physical therapy and rest. However EMG is not medically necessary while evaluating for shoulder pathology without evidence of cervical radiculopathy other than carpal tunnel syndrome.