

Case Number:	CM13-0009668		
Date Assigned:	06/06/2014	Date of Injury:	08/25/2010
Decision Date:	07/28/2014	UR Denial Date:	07/16/2013
Priority:	Standard	Application Received:	08/12/2013

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 Physical Medicine and Rehabilitation, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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 patient is a 55 year old male with a work injury dated 8/25/10 who was complaining of pain in the neck, shoulder blades and lower back following work-related accident on May 5, 2011. Her diagnoses include cervicobrachial syndrome, cervical myofascial pain, right shoulder strain, bicipital tendinitis right wrist strain, right carpal tunnel syndrome due to compressive neuropathy due use of the single-point cane, right knee internal derangement, lumbar radiculitis, sciatica, depressive mood disorder secondary to chronic pain. There is a 1/23/13 initial evaluation report that states that the patient had an EMG study performed in August 2011 which revealed evidence of a right median sensory mononeuropathy at or around the wrist. She had an MRI scan of the cervical spine performed on September 6, 2011 which revealed increased T4 signal intensity, disc protrusion at T1-12, and C5-C6 and C6-C7 degenerative disc disease with ligament thickening, central canal stenosis, and disc protrusion. MRI scan of the lumbar spine was also performed on September 6, 2011 suggested fracture of the anterior inferior corner of the L5 with evidence of intervertebral disc edema and avulsion of the anterior longitudinal ligament at the level of the L5 inferior disco vertebral junction. A left central disc protrusion at L5-S1 level increasing in severity with extension and simulated weight-bearing and effacing the L5 nerve root and the left neural foramina was noted. Face imbrication/arthrosis was noted at the L4-5 level increasing in severity with extension and persistent posterior discprotrusion at L3-4, L4-5 on neural and extension views. The treatment plan on this plan state that an EMG/NCS of the bilateral upper and lower extremities is requested to rule out lumbar and cervical radiculopathy versus peripheral nerve entrapment. A 3/27/13 progress report states that the patient complains of pain in the neck, upper back and shoulders with radiation to the arms. She has mid back pain and low back pain with radiation to the hip. The pain is associated with hand numbness. There are

complaints of numbness in the neck and shoulders and weakness in the arms/hands. The physical exam reveals decreased cervical range of motion. There is a negative Spurling sign. The lumbar spine reveals a negative straight leg raise test. The motor exam reveals 5/5 muscle strength in the bilateral upper extremities with 4/5 grip strength. There is decreased sensation in the right C7-C8 dermatomes in the upper extremities and bilateral L5-S1 dermatomes in the lower extremities. The reflexes are in the bilateral upper extremities and in the bilateral lower extremities. A 6/4/13 document states that a nerve conduction/EMG test of the of the upper and lower extremities is requested to assess for progressive neurological damage in light her functional deficits and her clinical evaluation; to rule out progressive cervical radiculopathy and lumbosacral radiculopathy. There is also a request for a repeat MRI of the cervical and lumbosacral spine to check for progressive deterioration of her degenerative disc disease. The document states that the patient is not a good surgical candidate at this time and a Functional Restoration Program is recommended based on her failure to improve with chiropractic, injections, and physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electrodiagnostic studies of bilateral upper and lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 117-179. Decision based on Non-MTUS Citation WWW.NLM.NIH.GOV/MEDLINEPLUS/LABORATORYTESTS.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

Decision rationale: Electrodiagnostic studies of the bilateral upper and lower extremities is not medically necessary per the MTUS ACOEM guidelines. The guidelines state that nerve conduction study and possibly EMG can be performed if severe nerve entrapment is suspected on the basis of physical examination, denervation atrophy is likely, and there is a failure to respond to conservative treatment. The guidelines also state that electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm or low back/leg symptoms, or both, lasting more than three or four weeks. The documentation indicates that patient has had a prior NCS/EMG of the upper extremities. Her symptoms appear chronic and the documentation indicates that she has failed conservative treatment including therapy and injections. She was deemed not a surgical candidate and is a candidate for FRP. The documentation is not clear how electrodiagnostic testing would change her management. The request therefore for electrodiagnostic studies of the bilateral upper and lower extremities is not medically necessary.

MRI of the cervical spine without contrast: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

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

Decision rationale: MRI of the cervical spine without contrast is not medically necessary per the MTUS ACOEM Guidelines. The guidelines state that criteria for ordering imaging studies are: emergence of a red flag or physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. The documentation submitted reveals that the patient has had chronic symptoms, failed all conservative management including injections and is not a surgical candidate. It is unclear how an MRI of the cervical spine without contrast is not medically necessary.

MRI of the lumbosacral spine without contrast: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303 AND 309, Chronic Pain Treatment Guidelines.

Decision rationale: MRI of the lumbar spine without contrast is not medically necessary per the MTUS ACOEM Guidelines. The guidelines state that unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. The documentation submitted reveals that the patient has had a prior lumbar MRI and has chronic symptoms, failed all conservative management including injections and is not a surgical candidate. The guidelines also state that an MRI can be considered if a patient has cauda equina, tumor, infection, or if fracture is strongly suspected. The documentation is not clear how an MRI of the lumbar spine would change the patient management. There is documentation that the patient has failed therapy, injections and is not a surgical candidate. The request for an MRI of the lumbar spine without contrast is not medically necessary.