

Case Number:	CM13-0010298		
Date Assigned:	09/20/2013	Date of Injury:	10/13/2011
Decision Date:	10/29/2014	UR Denial Date:	07/30/2013
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 Family 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:

This 41-year old man sustained an injury to his R upper extremity on 10/13/11 while moving a battery charger which fell off a pallet. According to a letter from a nurse case manager dated 12/7/12, the patient had a repair of a ruptured R biceps on 10/22/11, and a R carpal tunnel release on 8/9/12. His former doctor was ready to release him to full duty and make him permanent and stationary, but he refused to return to the doctor's office. He subsequently transferred care to his current primary treater. There are 5 progress notes from the primary treater in the available records. The first three are dated 2/18/13, 4/15/13, 5/13/13, and 6/10/13. They all state that the patient has pain in his right upper extremity. No physical exam is documented in three of the reports, except for the statement that the patient has no new motor or sensory deficits. The 5/13/13 report states that the patient has full range of motion of the upper extremity with pain, decreased sensation in the R C6-7 distribution, and weakness in the right upper extremity. Diagnoses include: rule out disc herniation in the cervical spine, and right shoulder impingement, both body parts not accepted; status post right biceps repair with residual pain and discomfort; and right hand carpal tunnel release, "positive on EMGs". The patient's work status is listed as temporarily totally disabled in the first three visits, and as modified with no use of the R upper extremity in the 6/10/13 report. There is one other handwritten note dated 7/22/13 from the primary provider in the record. It is nearly illegible, and contains only a few scribbled words. A request for authorization of EMG of upper extremities and MRI with contrast of the right elbow was submitted on 7/23/13.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG FOR THE RIGHT UPPER EXTREMITY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 170,171,178,182,Chronic Pain Treatment Guidelines Page(s): 6,10.

Decision rationale: The MTUS Guidelines cited above state that a thorough history and physical exam are important to establish and confirm diagnoses and to observe and understand pain behavior. Diagnostic studies should be ordered in this context and not simply for screening purposes. They also state that when a patient is diagnosed with chronic pain and the treatment for the condition is covered in the clinical topics sections but is not addressed in the chronic pain medical treatment guidelines, the clinical topics section applies to that treatment. Per the ACOEM neck and upper back chapter, patient evaluation should include neurological testing with focus on specific sensory, motor and reflex testing that may indicate specific nerve root dysfunction. Sensory testing should include light touch, pressure and pinprick sensations. Unequivocal findings that identify specific nerve root compromise are sufficient evidence to warrant imaging studies. If the findings are less clear, EMG and nerve conduction studies may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms. EMG is recommended to clarify nerve root dysfunction in cases of suspected disk herniation preoperatively or before epidural steroid injection. The clinical notes in this case do not document the performance of the kind of careful history, examination and thoughtful assessment prior to ordering testing that is recommended above. Most of the available notes do not document a physical exam. Pain is described in general terms, and it is not clear whether or not it is radicular. Only one note documents physical findings, which include weakness of the R upper extremity and numbness in the R C6-7 distribution. C6-7 numbness is the only clear finding documented that would suggest radiculopathy, but given the general sloppiness of the rest of the exam and documentation this finding is somewhat suspect. The probability that C6-7 radiculopathy is present would be higher if there were documented pain and weakness that also involved the C6 or C7 nerve roots. In addition, the provider has not indicated that surgery or epidural steroid injection is planned, so it does not appear that upper extremity EMG is needed in this case. According to the evidence-based guidelines cited above and the clinical findings in this case, EMG of the R upper extremity is not medically necessary. EMG is not medically necessary because the provider has not documented a careful history and exam with findings suggestive of radiculopathy and because there is no plan for surgery or epidural steroid injection that would warrant performance of an EMG.

NCV FOR THE RIGHT UPPER EXTREMITY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 170,171,178,182,Chronic Pain Treatment Guidelines Page(s): 6,10.

Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: UptoDate, an online, evidence-based review service for clinicians (www.uptodate.com), Overview of nerve conduction studies

Decision rationale: The MTUS Guidelines cited above state that a thorough history and physical exam are important to establish and confirm diagnoses and to observe and understand pain behavior. Diagnostic studies should be ordered in this context and not simply for screening purposes. They also state that when a patient is diagnosed with chronic pain and the treatment for the condition is covered in the clinical topics sections but is not addressed in the chronic pain medical treatment guidelines, the clinical topics section applies to that treatment. Per the ACOEM neck and upper back chapter, patient evaluation should include neurological testing with focus on specific sensory, motor and reflex testing that may indicate specific nerve root dysfunction. Sensory testing should include light touch, pressure and pinprick sensations. Unequivocal findings that identify specific nerve root compromise are sufficient evidence to warrant imaging studies. If the findings are less clear, EMG and nerve conduction studies may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms. Per the UptoDate reference cited above, nerve conduction studies are used to diagnose focal and generalized disorders of peripheral nerves, to aid in the differentiation of primary nerve and muscle disorders, and to classify peripheral nerve conduction abnormalities due to axonal degeneration, demyelination and conduction block. The clinical notes in this case do not document the performance of the kind of careful history, examination and thoughtful assessment prior to ordering testing that is recommended above. Most of the available notes do not document a physical exam. Pain is described in general terms, and it is not clear whether or not it is radicular. Only one note documents physical findings, which include weakness of the R upper extremity and numbness in the R C6-7 distribution. C6-7 numbness is the only clear finding documented that would indicate a nerve disorder, which in this case would be radiculopathy. There is no documentation of findings or suspicion of peripheral neuropathy. Nerve conduction studies are therefore not likely to be useful in this case. Based on the evidence-based citations above and the clinical findings in this case, nerve conduction studies (NCS) of the R upper extremity are not medically necessary. They are not medically necessary because the provider has not documented a careful history and exam with symptoms or findings suggestive of peripheral neuropathy. The findings he has documented might warrant EMG testing, but not NCS.

MRI OF THE RIGHT UPPER EXTREMITY: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines, Elbow Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Radiology Appropriateness Criteria, Chronic Elbow pain

Decision rationale: Per the ACR appropriateness criteria, there are multiple situations in which an MRI of the elbow without contrast would be indicated. These include: suspected intra-

articular osteocartilaginous body, suspected occult osteochondral injury, a suspected unstable osteochondral injury, suspected chronic epicondylitis, suspected collateral ligament tear, suspected biceps tendon tear and/or bursitis, and suspected nerve abnormality. All of these must have prior non-diagnostic radiography. An MRI without contrast is also appropriate if there is elbow stiffness and heterotopic ossification is suspected by radiography. There are two situations where MRI with contrast may be appropriate: suspected soft tissue mass with non-diagnostic radiography, and a suspected tumor identified on radiographs. It is not clear in this case why the treating physician has requested an MRI of the elbow with contrast. He has not documented concern about any of the possible diagnoses listed above that would warrant the performance of an elbow MRI. There is no documentation that he has performed any plain radiographs of the elbow. It seems unlikely that he would be concerned about a mass or tumor, which are the two situations that would warrant performance of an MRI with contrast. An MRI of the elbow would not be useful for diagnosing cervical radiculopathy, which is a concern that the primary treater has repeated documented. Based on the evidence-based guideline cited above, and the clinical findings in this case, an MRI of the right elbow without contrast is not medically necessary. It is not necessary because the provider has not documented any reason for ordering this test, and in particular has not documented a reason that would make an MRI with contrast an appropriate diagnostic test.