

Case Number:	CM13-0014246		
Date Assigned:	12/11/2013	Date of Injury:	03/16/2009
Decision Date:	03/11/2014	UR Denial Date:	08/12/2013
Priority:	Standard	Application Received:	08/20/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation 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 physician 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 claimant is a 30 year old injured worker, injured in a work related accident 03/16/09 sustaining an injury to the upper extremities and neck due to typing while at work. The medical records review includes a 10/2/13 QME which revealed the following; the patient does describe an occasional pain in the cervical spine that is increased by ADL's and decreased by rest. There are no upper extremity pains, there is no pain in the left shoulder, and there is no numbness throughout the entire aspects of both hands. There is a "tired" sensation in the left upper extremity. Medical records regarding the patient's neck states that there were no point tenderness, there was significant paravertebral spasm, guarding, and asymmetric loss of range of motion. Records regarding the patient's upper extremities states there was circumferential measurements made in the upper arms at the mid biceps level, right over left; 36.5/37.0 cm; and circumferential measurements were made in the forearms, right over left; 30.5/31.0 cm. The shoulder range of motion was right over left; abduction 180/180, flexion 180/180, internal rotation 90/90, external rotation 90/90, extension 60/60, and adduction 60/60 degrees. The Dislocation Apprehension and Drop Arm tests were negative bilaterally. The impingement testing was positive on the left and negative on the right. Elbow range of motion, right/left; extension 0/10 and flexion 140/140 degrees. Forearm rotation was right/left; supination 90/90 and pronation 80/80 degrees. Wrist range of motion was right/left; extension, 60/60, flexion 60/60, ulnar deviation 30/30, and radial deviation 20/20 degrees. There was a 2 cm left carpal tunnel release and an 11 cm poster medial left elbow surgical scar. There was a positive Tinel examination over the left median nerve and the transposed left ulnar nerve. There was a negative Tinel examination over the right median and ulnar nerves. The provocative testing for an epicondylitis and the Finkelstein tests were negative bilaterally. There was minimal swelling over the medial aspect of the left elbow. Medical records regarding neurologic state that manual

muscle testing revealed grade 4-5/5 strength of the left hand intrinsic with testing otherwise intact. The Jamar grip strength, right/left, 50, 44, 32/55, 55, 47 pounds, second setting. Sensation was decreased to soft touch throughout the entire left hand but two points was intact and sensation testing was otherwise intact. The deep tendon reflexes, right/left, biceps 2+/2+, triceps 2+/2+, quadriceps 2+/2+, and gastroc soleus 2+/2+. The diagnostic impression: status post left carpal tunnel release with flexor tenosynovectomy, 9-30-09; recurrent left carpal tunnel syndrome; status post left ulnar nerve transposition, 7-21-10; left ulnar neuritis; history of clinical right carpal tunnel syndrome; bilateral wrist/hand sprain/strain; left upper extremity sprain/strain; left shoulder sprain with impingement and possible internal derangement; rule out cervical radiculopathy. The recommended treatment included: MRI study of the cervical spine and an EMG and nerve conduction study of both upper extremities and the cervical paraspinals. The patient can utilize oral medications with the appropriate precautions as well as appropriate bracing. There is a potential of additional future surgical interventions for the upper extremities. The primary treating physician's initial orthopedic evaluation, dated 7/29/13, states the following, Cervical Spine: on examination of the cervical spine, there was tenderness, guarding and spasms noted in the left paravertebral region. There were trigger points noticeable in the upper trapezius muscles bilaterally. The manual muscle testing revealed 4/5 strength with flexion, extension, bilateral rotation and bilateral lateral flexion. Range of motion was restricted due to pain and spasm. The EMG/NCS, dated 11/16/13, revealed the following; the electrodiagnostic and nerv

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the cervical spine: 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: Based on the American College of Occupational and Environmental Medicine Guidelines, the patient does not meet the criteria for ordering cervical imaging studies. The patient has no radicular or red flag symptoms on physical examination. Furthermore the ACOEM guidelines state that "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." Based on the medical records provided for review there are no suggestions of nerve compromise on neurologic exam in this patient. The request for a MRI of the cervical spine is not medically necessary and appropriate.