

Case Number:	CM13-0029517		
Date Assigned:	12/18/2013	Date of Injury:	04/24/2012
Decision Date:	02/28/2014	UR Denial Date:	09/12/2013
Priority:	Standard	Application Received:	09/26/2013

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 Pain Management 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 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:

Comprehensive orthopedic panel QME report dated 09/04/12 indicates that the claimant sustained an industrial injury dated 04/24/12. The claimant reports cumulative trauma attributed to the injury sustained in the neck, shoulders, and arms. Currently, the claimant complains of intermittent sharp and aching pain in the neck and upper back radiating down the shoulders associated with stiffness, numbness, and tingling sensation in the hands and fingers that is aggravated with fixed position, prolonged sitting, and standing and relieved with pain medications, heating pads, cervical pillow, and use of hot/cold gel. The claimant also reports locking sensation in the left middle finger and popping sensation in the shoulders. Pain is aggravated with reaching, moving arms backwards, and lifting the upper extremity above shoulder level. The claimant complains of cramping pain associated with weakness in the wrist and hands that is aggravated with forceful grasping, gripping, repetitive flexing and extending, rotating, repetitive arms, hands, and finger movement. The claimant reports stomach irritation due to consumption of the anti-inflammatory and pain medications. The claimant complains of difficulty sleeping. The claimant reports depression, stress, anxiety, sadness, frustrations, depression, anguished, and irritation. The claimant also has crying spells, isolate from family and friends and lacks motivation to do any activities. The claimant reports difficulty performing activities of daily living. Examination of the cervical spine shows swelling over the suprascapular area bilaterally. There is moderate tenderness over the suprascapular area, upper trapezoid and interscapular area. There is limitation of motion with cervical flexion at 45 degrees, extension at 45 degrees, right lateral flexion at 45 degrees, left lateral flexion at 45 degrees, right rotation at 60 degrees, and left rotation at 60 degrees. Examination of the lumbar spine shows tenderness over the lumbar paravertebral musculature. There is muscle tightness in the lumbar paravertebral musculature. There is muscle guarding in the lumbar spine. There is limitation of

motion with lumbar forward flexion at 30 degrees, extension at 15 degree, right lateral flexion at 15 degrees, left lateral flexion at 15 degrees, right rotation at 15 degrees, and left rotation at 15 degrees. Muscle strength in the bilateral lower extremities is grossly 4-5/5. There is mild diminished sensation over the L5 nerve root. Gait analysis shows mild antalgic gait. The claimant can return to work with restrictions including typing activities not more than 15 minutes, no lifting, pushing, pulling or grasping more than 2 to 4 pounds and limited to 50 cases. The provider recommends MRI of the cervical spine, lumbosacral spine, bilateral wrists, right knee and EMG/NCV of the bilateral upper and lower extremities. Initial orthopedic comprehensive evaluation report dated 03/18/13 indicates that the claimant sustained an industrial injury dated 04/25/12. The claimant was inputting data into the computer and experiences onset of sharp pain in the left hand and palm. The claimant reports gradual pain in the shoulders, right wrist, and hand. In 2003 the claimant reports pain in the neck and low back area. The provider notes that the claimant has prior six physical therapy in the neck, shoulders, wrist, and hands with no noted significant pain relief. Currently, the claimant complains of aching, sharp and shooting pain the neck down the arms and hands associated with stiffness and intermitted numbness and tingling sensation in the arms and hands that is aggravated with prolonged sitting and keeping the neck in a fixed position. The claimant also complains of frequent headaches and difficulty sleeping. The claimant also reports constant aching, sharp and throbbing pain in the shoulder radiating down the arms and hands that is aggravated with reaching, pushing, pulling and lifting activities. The claimant

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI Cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-TWC: Low Back - Lumbar & Thoracic (Acute & Chronic)(updated 12/27/13)-Imaging-MRI

Decision rationale: The provider has requested for MRI Cervical spine, and the guideline stipulates that the 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". None of these indications are documented on the most recent examination. The guideline further stated: 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. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation). (Bigos, 1999) (Mullin, 2000)

(ACR, 2000) (AAN, 1994) (Aetna, 2004) (Airaksinen, 2006) (Chou, 2007). The most recent note reports tenderness and spasm are present. Therefore the request for repeat MRI of the Cervical Spine is not medically necessary.

MRI lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-TWC: Low Back - Lumbar & Thoracic (Acute & Chronic)(updated 12/27/13)-Imaging-MRI

Decision rationale: The provider has requested for MRI of the lumbar spine, and the guideline stipulates that the 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". None of these indications are documented on the most recent examination. The guideline further stated: 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. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation). (Bigos, 1999) (Mullin, 2000) (ACR, 2000) (AAN, 1994) (Aetna, 2004) (Airaksinen, 2006) (Chou, 2007). The most recent note reports tenderness and spasm are present. Therefore the request for repeat MRI of the lumbar is not medically necessary.

Electrodiagnostic studies of the upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints
Page(s): 117-118.

Decision rationale: The provider has requested for Electrodiagnostic studies of the upper extremities, and the guideline states: "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. Additional studies may be considered to further define problem areas.. In March 2013, there was decreased

sensation to pain C6-7 dermatomes bilaterally and L5-S1 on the left. Right knee strength noted as 4/5 and deltoid also noted as 4/5 bilaterally. There was no documentation of any subtle neurological findings that will require additional electrophysiological studies. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. The claimant had a previous EMG/NCV study performed in 9/18/2012 which indicated possible left C8 or C7 radiculopathy, or a possible plexus compression, left more than right, based on reduced amplitudes for median motor studies, as the good latency preservations imply that this would be less likely from a carpal tunnel picture. Therefore the request for a repeat EMG/NCVS is not medically necessary.

Functional capacity evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 117-118.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines 2nd Ed., Independent Medical Examinations and Consultations

Decision rationale: With respect to Functional Capacity Evaluation, ACOEM (2004) in page 4 states: Workers may vary in their capacity to lift, exert force, perform fine motortasks, etc. according to general or specific health status, age, conditioning, size, strength, and other factors. Physical functional abilities rise and fall over the worker's lifespan. Abilities also vary from worker to worker depending on conditioning, impairment, and innate capacity. The decline in cardiorespiratory and musculoskeletal functional capacity with age can be delayed or accelerated by physical conditioning (or lack thereof), overuse, illness (including chronic pain), and injury. The request for functional capacity evaluation is not medically necessary, since the patient is still working, but on a restricted work schedule. California MTUS notes, "There is little scientific evidence confirming that FCEs predict an individual's actual capacity to perform in the workplace; an FCE reflects what an individual can do on a single day, at a particular time, under controlled circumstances, that provide an indication of that individual's abilities". ODG notes that an FCE should be performed if there is prior unsuccessful RTW attempts. But this patient is currently working, but on a restricted job schedule.

Electrodiagnostic studies of the lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 117-118.

Decision rationale: The provider has requested for Electro-diagnostic studies of the lower extremities and the guideline states: "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. Additional studies may be considered to further define problem areas.. In March 2013, there was decreased sensation to pain C6-7 dermatomes bilaterally and L5-S1 on the left. Right knee strength noted as 4/5 and deltoid also noted as '4/5 bilaterally. There was no documentation of any subtle neurological findings that will require additional electrophysiological studies. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. The claimant had a previous EMG/NCV study performed in 9/18/2012 which indicated possible left C8 or C7 radiculopathy, or a possible plexus compression, left more than right, based on reduced amplitudes for median motor studies, as the good latency preservations imply that this would be less likely from a carpal tunnel picture. Therefore the request for a repeat EMG/NCVS is not medically necessary.