

Case Number:	CM13-0032785		
Date Assigned:	12/06/2013	Date of Injury:	09/12/2012
Decision Date:	02/10/2014	UR Denial Date:	08/23/2013
Priority:	Standard	Application Received:	10/08/2013

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 Family Medicine and is licensed to practice in North Carolina. 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 patient is a 46 year old with a reported date of injury on 09/12/2012 when he was stuck by a car while riding his [REDACTED] motorcycle. Post-accident he was evaluated in the emergency room and diagnosed with a broken collarbone. Since the date of injury he has had a thoracic MRI on 10/17/2012 which was reported as normal, a right shoulder MRI on 09/20/2012 which showed a mildly displaced fracture of the distal clavicle a small partial tear of the supraspinatus tendon, and a cervical MRI on 09/20/2012 which was normal. His treatment course has included medication and physical therapy. A progress note from 11/20/2012 notes the patient reports " no longer have pain in the ribs or the right thoracic spine..occasional paresthesias radiating down the left arm." Physical exam on that date noted cervical range of motion is full in all planes with no reproduction of symptoms, no tenderness to palpation over the cervical spine, 1+ supraspinatus tendon sign, no weakness with internal or external rotation of the shoulder and a positive Roos test on the left. The physician recommended full return to work, possibility of refill of medication and further diagnostic testing should paresthesias increase, and continued physical therapy. There is a utilization review decision which mentions another physician's notes from 7/22/13 which states the patient claims intermittent pain, rated 8/10 in the cervical spine and thoracic spine radiating to the left greater than the right with numbness and migraines. Treatments rendered include bilateral upper extremity electromyography (EMG)/nerve conduction velocity (NCV), MRI of the thoracic and cervical spine and referral for cervical spine/thoracic spine epidural injections and medication. However there are no actual physician notes past the one dated 11/20/2012 included with the documentation. Another utilization review dated 08/23/13 failed to certify the MRI of the thoracic spine, MRI of the cervical spine and the EMG/NCV

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI thoracic spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Campbell's Operative Orthopaedics, 10th ed. Chapter 39 - Lower Back Pain and Disorders of Intervertebral Discs.

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

Decision rationale: The California MTUS addresses MRI in the setting of chronic upper back and neck complaints in the ACOEM section as follows: Special Studies and Diagnostic Treatment Considerations: For most patients presenting with true neck or upper back problems, special studies are not needed unless a three- or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out. 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 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. 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. If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps, including the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, compute tomography [CT] for bony structures). Additional studies may be considered to further define problem areas. The recent evidence indicates cervical disk annular tears may be missed on MRIs. The clinical significance of such a finding is unclear, as it may not correlate temporally or anatomically with symptoms. There is no support documentation provided addressing any of the criteria listed above that would justify an additional imaging test to define a potential cause and thus cannot be certified. In addition previous thoracic MRI performed in 09/2012 was normal.

MRI of cervical spine: Upheld

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

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

Decision rationale: The California MTUS addresses MRI in the setting of chronic upper back and neck complaints in the ACOEM section as follows: Special Studies and Diagnostic Treatment Considerations: For most patients presenting with true neck or upper back problems, special studies are not needed unless a three- or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out. 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 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. 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. If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps, including the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, compute tomography [CT] for bony structures). Additional studies may be considered to further define problem areas. The recent evidence indicates cervical disk annular tears may be missed on MRIs. The clinical significance of such a finding is unclear, as it may not correlate temporally or anatomically with symptoms. There is no support documentation provided addressing any of the criteria listed above to consider additional imaging studies to define potential causes of finding on physical exam and thus cannot be certified. In additional previous cervical MRI in 09/2012 was normal.

EMG/NCV bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-TWC Neck and Upper Back Procedure Summary

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

Decision rationale: The California MTUS addresses EMG/NCV in the setting of chronic upper back and neck complaints in the ACOEM section as follows: Special Studies and Diagnostic Treatment Considerations: For most patients presenting with true neck or upper back problems, special studies are not needed unless a three- or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out. 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 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. 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. If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps, including the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, compute tomography [CT] for bony structures). Additional studies may be considered to further define problem areas. The recent evidence indicates cervical disk annular tears may be missed on MRIs. The clinical significance of such a finding is unclear, as it may not correlate temporally or anatomically with symptoms. There is no support documentation provided addressing any of the criteria listed above and thus cannot be certified. The most recent included progress notes dated 11/20/2012 only mentions subjective occasional upper extremity paresthesias and no physical exam deficits. There is no other physician documentation showing any change in these findings and thus no support for EMG/NCV.