

Case Number:	CM13-0058149		
Date Assigned:	12/30/2013	Date of Injury:	08/10/2013
Decision Date:	03/25/2014	UR Denial Date:	11/25/2013
Priority:	Standard	Application Received:	11/26/2013

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 Physical Medicine and Rehabilitation 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:

Prior treatment included physical therapy, TENS unit, home exercise program, and medications. CT of the head showed no skull fractures and a C spine x-ray showed degenerative changes of the C5-C4 with osteophyte. The patient underwent left shoulder arthroscopic surgery on 09/11/2013. Cervical spine x-ray dated 08/11/2013 showed cervical spine straightening; no acute fracture or spondylolisthesis and moderate to severe degenerative disc disease at C4-5. An X-ray of the left shoulder also taken on the same day revealed no fracture, dislocation, periarticular osteoporosis, lytic lesions or Osteoarthritis of the A.C. joint. No acute findings. A clinic note dated 11/06/2013 indicates the patient completed 16 session of postoperative physical therapy to left shoulder and has approximately 6 more treatment sessions, which is helping with shoulder motion. The patient also reported neck pain radiating to the left upper extremity. On examination of the cervical spine, there was tenderness to palpation with spasm over the paravertebral musculature and trapezius muscles. Axial compression test was positive eliciting increased neck pain radiating to the left upper extremity. Sensation was decreased over the left C6 and C7 dermatomes. Cervical distraction test was positive. Range of motion of the cervical spine with flexion 40, extension 42, right side bending 32, left side bending 32, right rotation 60, and left rotation 62. On left shoulder exam, there was tenderness to palpation over the periscapular muscles, trapezius muscle, subacromial region and acromioclavicular joint. Range of motion of the left shoulder was decreased. Diagnoses were cervical/trapezial musculoligamentous sprain/strain with left upper extremity radiculitis with MRI dated 05/11/2010 revealing multilevel disc bulges, osteophyte complex and stenosis. The current review is for 1 MRI cervical Spine; 1 EMG left upper extremity; 1 EMG right upper extremity; 1 NCV left upper extremity; 1 NCV right upper extremity and continued physiotherapy for left shoulder twice a week for 4 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI Cervical Spine Qty 1: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM,Chronic Pain Treatment Guidelines.

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

Decision rationale: As per CA MTUS guidelines, MRI is recommended 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 for neural or other soft tissue. The provider's note dated 11/06/2013 indicates that there are objective findings of decreased sensation over left C6 and C7 dermatomes, positive Axial compression test producing increased pain radiating to the left upper extremity, positive cervical distraction test, and decreased cervical ROM. These findings indicate that the medical necessity has been established to warrant cervical MRI and hence the request is certified.

EMG Left Upper Extremity Qty 1: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM,Chronic Pain Treatment Guidelines.

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

Decision rationale: As per CA MTUS guidelines for EMG, unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. Records submitted revealed there is documentation of abnormal neurologic findings of diminished sensation on exam. These findings indicate that the medical necessity has been established to warrant EMG study and therefore the request is certified.

EMG Right Upper Extremity Qty 1: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM,Chronic Pain Treatment Guidelines.

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

Decision rationale: As per CA MTUS guidelines for EMG, unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant

imaging studies if symptoms persist. Records submitted revealed there is documentation of abnormal neurologic findings of diminished sensation on exam. These findings indicate that the medical necessity has been established to warrant EMG study and therefore the request is certified.

NCV Left Upper Extremity Qty 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM,Chronic Pain Treatment Guidelines.

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

Decision rationale: As per CA MTUS guidelines, NCVs are recommended if unequivocal findings that identify specific nerve compromise on the neurologic examination. As per ODG, NCVs are recommended to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely based on the clinical exam. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy." This patient was diagnosed with cervical/trapezial musculoligamentous sprain/strain with left upper extremity radiculitis. The provider has requested the study due to worsening of neck pain radiating to left upper extremity. Thus, the medical necessity has not been established and the request is non-certified.

NCV Right Upper Extremity Qty 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM,Chronic Pain Treatment Guidelines.

MAXIMUS 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)

Decision rationale: As per CA MTUS guidelines, NCVs are recommended if unequivocal findings that identify specific nerve compromise on the neurologic examination. As per ODG, NCVs are recommended to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely based on the clinical exam. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy." This patient was diagnosed with cervical/trapezial musculoligamentous sprain/strain with left upper extremity radiculitis. The provider has requested the study due to worsening of neck pain radiating to left upper extremity. Thus, the medical necessity has not been established and the request is non-certified.

Continued Physiotherapy Left Shoulder 2 Times Week For 4 Weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM,Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

Decision rationale: As per CA MTUS postsurgical treatment guidelines, 24 sessions over 14 weeks. As per provider's report dated 11/06/2013, the patient completed 16 sessions of postop physical therapy and 6 more treatment sessions were left. This results in a total of 22 sessions considering the number of sessions completed and left. The request for continued postop physical therapy 2 x4 weeks (total 8 sessions) will exceed the guidelines recommendation and hence the request is non-certified.