

Case Number:	CM14-0011411		
Date Assigned:	04/25/2014	Date of Injury:	10/29/2013
Decision Date:	06/09/2014	UR Denial Date:	12/24/2013
Priority:	Standard	Application Received:	01/28/2014

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 Physical Medicine & Rehabilitation and is licensed to practice in Illinois. 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:

The injured worker is a 36 year old male who reported an injury on 10/29/2013 secondary to a motor vehicle accident. The diagnoses include cervical intravertebral disc displacement without myelopathy, left upper extremity radiculopathy, tendonitis of the left shoulder, and lumbar strain. The MRIs of the cervical and lumbar spine dated 02/04/2014 indicated herniation of the C5-6 disc, small to moderate and central in location with mild disc bulging at C6-7. The study also noted mild lumbar stenosis at L4-5. The injured worker was evaluated on 04/01/2014 for reports of sharp radiating pain to the shoulders rated at 7/10; sore, achy, tingling pain to the right shoulder rated at 5/10; and low back stiffness rated at 3/10. The exam noted loss of range of motion of the cervical spine, positive cervical compression, positive Spurling's and Hoffman's, instability in the Romberg's position. The exam also noted decreased range of motion of the right shoulder, positive Hawkin's and Neer's. The injured worker was also evaluated on 04/04/2014 for complaints of neck pain and low back pain. The exam noted the injured worker's current medications as Tylenol and ibuprophen. The exam noted a work related injury to the left wrist that had gradually improved. The exam also noted full flexion, extension of 50 degrees right and left lateral tilt of 75 degrees range of motion of the cervical spine with mild tenderness from C5-T1. A positive left trapizial sign was also noted with no motor weakness or muscle atrophy noted. The exam also noted positive pinprick over medial aspect of right hand and bicep reflexes of zero bilaterally. The bilateral lower extremities were noted to have no motor weakness or sensory abnormalities. Midline tenderness was noted to L4-S1. The treatment plan includes an MRI of the right shoulder, EMG/NCV of the and bilateral upper and lower extremities. Request for authorization form for EMG/NCV was received.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI OF THE RIGHT SHOULDER: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, MRI.

Decision rationale: The American College of Occupational and Environmental Medicine (ACOEM) guidelines and the Official Disability Guidelines (ODG) guidelines recommend imaging studies when the injured worker has failed conservative care and evidence of red flags. The physical exam noted the injured worker has loss of range of motion to the right shoulder. The exam also noted ibuprofen use; however, there is no evidence of trials of other NSAID's, physical therapy or other red flags to warrant the imaging studies requested. Based on the documentation provided, the request is not medically necessary.

EMG/NCV OF THE BILATERAL UPPER EXTREMITIES: 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): 177-179.

Decision rationale: The California MTUS/ACOEM guidelines state EMG studies can help identify subtle dysfunction in patients with both neck and arm symptoms lasting more than three to four weeks when there is an emergence of a red flag, evidence of tissue insult or dysfunction, failure to progress in a strengthening program. The injured worker has had reports of shoulder pain and evidence of neurological deficit has been noted to the upper extremities; however, there is no evidence of conservative treatment measures such as medication and physical therapy or any red flags. Based on the documentation provided, the request is non-certified.

EMG/NCV OF THE BILATERAL LOWER EXTREMITIES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation ODG, Low Back Chapter, Nerve Conduction Studies.

Decision rationale: The California MTUS/ACOEM guidelines state EMG studies can help identify subtle dysfunction in patients with low back symptoms lasting more than three to four

weeks when there is an emergence of a red flag, evidence of tissue insult or dysfunction, failure to progress in a strengthening program. ODG state NCV are not recommended on for suspected radiculopathy. They are considered to have limited overall diagnostic accuracy. The injured worker has had reports of low back stiffness; however, there is no evidence noted of neurological symptoms, conservative treatment measures such as medication and physical therapy or any red flags. In addition, there is a lack of evidence to suggest a diagnosis of peripheral neuropathy. Based on the documentation provided, the request is not medically necessary.

PURCHASE OF A RIGHT WRIST BRACE: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), FOREARM, WRIST & HAND CHAPTER, BRACE/SPLINT.

Decision rationale: Official Disability Guidelines states that wrist splints are recommended for displaced fractures, rheumatoid arthritis, following tendon repair and for arthritis. There is no evidence of these diagnoses to the right wrist in the documentation provided. Based on the documentation provided, the request is not medically necessary.

PURCHASE OF A THERMOCOOL SYSTEM FOR THE NECK AND LOW BACK: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low 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), NECK AND LOW BACK CHAPTERS, CRYOTHERAPY.

Decision rationale: Official Disability Guidelines states that cold/hot pack are warranted in the acute phase. There is a lack of evidence to support cryotherapy units over hot/cold packs in the cervical and lumbar spine regions. The injured worker has had complaints of cervical and lumbar spine for since the reported injury on 10/29/2013. Therefore, the time of request exceeds the acute phase. Based on the documentation provided, the request is not medically necessary.