MAXIMUS Federal Services

Case Number:	CM14-0152486		
Date Assigned:	09/22/2014	Date of Injury:	06/30/2014
Decision Date:	10/21/2014	UR Denial Date:	08/29/2014
Priority:	Standard	Application Received:	09/18/2014

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 Family Medicine, 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 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:

This is a 52-year-old female patient who reported an industrial injury on 6/30/2014, almost four (4) months ago, attributed to the performance of her usual and customary job tasks. The patient was diagnosed with a cervical strain and left upper extremity contusion. The patient was provided conservative care to the left upper extremity. A MRI of the left shoulder documented a SLA P lesion for which the patient was referred to an orthopedic surgeon. The patient complained of intermittent numbness and tingling in the distal left upper extremity. The treatment plan included a referral to an orthopedic surgeon for the shoulder symptoms; a MRI of the cervical spine; and an EMG/NCs of the left upper extremity.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCS of the Left Upper Extremity: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disabilities Guidelines (ODG) Integrated Treatment Guidelines (ODG Treatment in Workers Comp 2nd Edition) Disability Duration Guidelines (Official Disability Guidelines 9th Edition)/Work Loss Data Institute.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints Page(s): 48; 178; 261; 298, 301, 303. Decision

based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and upper back--electromyography; Carpal Tunnel Syndrome--EDS

Decision rationale: The request for the authorization of the EMG/NCS of the LUE is not supported with sufficient objective clinical findings that would contribute to the future treatment plan of the patient and is not supported by any changes in objective findings documented on examination. There are no documented progressive neurological deficits to support the medical necessity of Electrodiagnostic studies. The evaluation to rule out a peripheral nerve entrapment or cervical radiculopathy is not supported with the documented objective findings documented on examination. There is no demonstrated medical necessity for the requested Electrodiagnostic studies without the failure of conservative treatment. There are no objective or subjective findings documented that require immediate Electrodiagnostic studies as no surgical intervention is contemplated and the patient has not failed injections and HEP. The Electrodiagnostic studies were ordered due to reported right upper extremity numbness. There are only symptoms with objective findings documented for the left upper extremity and no symptoms documented for the right upper extremity. There are no documented changes in the neurological status of the patient that would require Electrodiagnostic studies. The clinical narrative documented that the Electrodiagnostic studies were ordered as screening studies. There is no demonstrated medical necessity for the requested LUE EMG/NCS screening examination. The patient was recommended to be evaluated by an orthopedic surgeon for her shoulder complaints, which would be appropriate prior to the evaluation of the patient with Electrodiagnostic studies.The provider has documented no objective findings on examination to be further evaluated with Electrodiagnostic studies prior to the provision of conservative treatment. There are subjective findings; however, there are no significant neurological deficits documented that require Electrodiagnostic studies. The Electrodiagnostic test is ordered as a screening test. There is no contemplated surgical intervention for a cervical radiculopathy or peripheral nerve entrapment neuropathy. There is no demonstrated impending surgical intervention being contemplated and the patient has not completed ongoing conservative care. There is no objective evidence that the patient has median or ulnar entrapment neuropathy that would qualify for surgical intervention. The EMG/NCS is for diagnostic purposes for cervical radiculopathy or peripheral nerve compression neuropathy, which are not documented by objective findings. The EMG/NCS would be helpful to assess the medical necessity of a peripheral nerve decompression; however, the patient has not been demonstrated to have failed conservative treatment or treatment to the shoulder. There is no medical necessity for the requested Electrodiagnostic studies for the evaluation of the patient at this time prior to the provision of conservative treatment. The current clinical objective findings did not demonstrate a significant change in the clinical status of the patient as to nerve entrapment neuropathies and there was not rationale for the requested Electrodiagnostic study other than to "rule out" a nerve compression neuropathy or a nerve root impingement neuropathy with a screening study. There were no documented clinical changes or objective findings to support the medical necessity of a LUE EMG/NCS study. The EMG/NCS would only be necessary to evaluate for the medical necessity of surgical intervention for moderate to severe symptoms with objective findings documented on examination. The criteria recommended by the CA MTUS, the ACOEM Guidelines or the Official Disability Guidelines for the use of Electrodiagnostic studies for the BUEs were not documented by the requesting provider. There was no demonstrated objective evidence, such as, a neurological deficit or change in status is that supports the authorization of EMG/NCS studies. There is no demonstrated medical necessity to evaluate for a bilateral upper extremity radiculopathies or peripheral neuropathies based on the objective findings documented.

MRI of the Cervical Spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182, 177-178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck and upper back chapter-MRI

Decision rationale: The request for a MRI of the cervical spine was not supported with objective findings on examination to support medical necessity. The patient is four (4) months s/p DOI and has no documented neurological or radiculopathy deficits on examination. There was no objective evidence to support the medical necessity of the requested cervical spine MRI. The patient was not documented to have been provided complete conservative treatment. The criteria recommended by evidence-based guidelines were not documented to support the medical necessity of the requests. There is no rationale provided by the requesting provider to support the medical necessity of a MRI of the cervical spine as a screening study. There are no documented progressing neurological deficits. There are no demonstrated red flag diagnoses as recommended by the ACOEM Guidelines in order to establish the criteria recommended for a MRI of the cervical spine. The medical necessity of the requested MRI of the cervical spine was not supported with the subjective/objective findings recommend by the ACOEM Guidelines or the Official Disability Guidelines for the authorization of a cervical spine MRI. The patient's treatment plan did not demonstrate an impending surgical intervention or any red flag diagnoses. The treatment plan was not demonstrated to be influenced by the obtaining of the Cervical MRI. There were no demonstrated sensory or motor neurological deficits on physical examination; there were no demonstrated changes to the patient's neurological examination other than the subjective pain complaint; and the patient was not shown to have failed a conservative program of strengthening and conditioning. The patient is not documented as contemplating surgical intervention to the cervical spine. There were no documented clinical changes in the patient's clinical status or documented motor/sensory neurological deficits that would warrant the authorization of a MRI of the cervical spine/thoracic spine or meet the recommendations of the currently accepted evidence-based guidelines. There is no provided rationale for the MRI of the cervical spine/thoracic spine by the requesting provider. The MRI results were not noted to affect the course of the recommended conservative treatment. The functional assessment for the provided conservative therapy since the date of injury has not been documented or provided in the physical therapy documentation. There was no demonstrated medical necessity for a MRI of the cervical spine. Therefore, this request is not medically necessary.