

<b>Case Number:</b>	CM14-0161645		
<b>Date Assigned:</b>	11/06/2014	<b>Date of Injury:</b>	12/23/2010
<b>Decision Date:</b>	12/09/2014	<b>UR Denial Date:</b>	09/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/01/2014

### 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 Anesthesiology, has a subspecialty 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 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:

According to the records made available for review, this is a 51-year-old female with a 12/20/10 date of injury. At the time (8/4/14) of the request for authorization for EMG of the bilateral upper extremities, NCV bilateral upper extremities, and MRI neck, there is documentation of subjective (depression, headaches, right elbow/wrist symptoms) and objective (decreased cervical spine range of motion, positive sensation defect C5 and C6, decreased range of motion right shoulder) findings, imaging findings (MRI cervical spine (4/9/14) report revealed post-surgical changes at the C5-6 level with interbody fusion and anterior fixation. C5-6 susceptibility artifact obscures some detail. There is a 2-3 mm lateralizing bulge or protrusion, somewhat smaller than the prior study with moderately severe right neural foraminal stenosis, appearing stable as compared to the prior study. There is moderate left neural foraminal stenosis as well. There is mild central stenosis. C3-4 there is a 1-2 mm leftward bulge or protrusion, stable as compared to the prior study with mild left neural foraminal stenosis. The central canal is slightly reduced. C6-7 there is a 1 mm bulge. There is mild central canal narrowing. The foramina are maintained), current diagnoses (bursitis right shoulder, herniated cervical disc injury, cervical spine surgery 8/19/13, radiculopathy right upper extremity, impingement syndrome right shoulder, and right shoulder surgery 8/12/11), and treatment to date (medication). Regarding MRI neck, there is no documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a repeat study is indicated (such as: To diagnose a suspected fracture or suspected dislocation, to monitor a therapy or treatment which is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment (repeat imaging is not appropriate solely to determine the efficacy of physical therapy or chiropractic treatment), to follow up a surgical procedure, to diagnose a change in the patient's condition marked by new or altered physical findings).

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **EMG of the bilateral upper extremities:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177,33.

**Decision rationale:** MTUS reference to ACOEM identifies documentation of subjective/objective findings consistent with radiculopathy/nerve entrapment that has not responded to conservative treatment, as criteria necessary to support the medical necessity of EMG/NCV. Within the medical information available for review, there is documentation of diagnoses of bursitis right shoulder, herniated cervical disc injury, cervical spine surgery 8/19/13, radiculopathy right upper extremity, impingement syndrome right shoulder, and right shoulder surgery 8/12/11. In addition, given documentation of objective (decreased cervical spine range of motion, positive sensation defect C5 and C6, and treatment to date (medication), there is documentation of subjective/objective findings consistent with radiculopathy/nerve entrapment that has not responded to conservative treatment. Therefore, based on guidelines and a review of the evidence, the request for EMG of the bilateral upper extremities is medically necessary.

### **NCV bilateral upper extremities:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177,33.

**Decision rationale:** MTUS reference to ACOEM identifies documentation of subjective/objective findings consistent with radiculopathy/nerve entrapment that has not responded to conservative treatment, as criteria necessary to support the medical necessity of EMG/NCV. Within the medical information available for review, there is documentation of diagnoses of bursitis right shoulder, herniated cervical disc injury, cervical spine surgery 8/19/13, radiculopathy right upper extremity, impingement syndrome right shoulder, and right shoulder surgery 8/12/11. In addition, given documentation of objective (decreased cervical spine range of motion, positive sensation defect C5 and C6, and treatment to date (medication), there is documentation of subjective/objective findings consistent with radiculopathy/nerve

entrapment that has not responded to conservative treatment. Therefore, based on guidelines and a review of the evidence, the request for NCV bilateral upper extremities is medically necessary.

**MRI neck:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC); Neck and Upper Back Procedure Summary.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-183. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Minnesota Rules, 5221.6100 Parameters for Medical Imaging.

**Decision rationale:** MTUS reference to ACOEM Guidelines identifies documentation of red flag diagnoses where plain film radiographs are negative, physiologic evidence (in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans) of tissue insult or neurologic dysfunction, failure of conservative treatment; or diagnosis of nerve root compromise, based on clear history and physical examination findings, in preparation for invasive procedure; as criteria necessary to support the medical necessity of an MRI. ODG identifies documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a repeat study is indicated (such as: To diagnose a suspected fracture or suspected dislocation, to monitor a therapy or treatment which is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment (repeat imaging is not appropriate solely to determine the efficacy of physical therapy or chiropractic treatment), to follow up a surgical procedure, to diagnose a change in the patient's condition marked by new or altered physical findings) as criteria necessary to support the medical necessity of a repeat MRI. Within the medical information available for review, there is documentation of diagnoses of bursitis right shoulder, herniated cervical disc injury, cervical spine surgery 8/19/13, radiculopathy right upper extremity, impingement syndrome right shoulder, and right shoulder surgery 8/12/11. In addition, there is documentation of a previous MRI. However, there is no documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a repeat study is indicated (such as: To diagnose a suspected fracture or suspected dislocation, to monitor a therapy or treatment which is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment (repeat imaging is not appropriate solely to determine the efficacy of physical therapy or chiropractic treatment), to follow up a surgical procedure, to diagnose a change in the patient's condition marked by new or altered physical findings). Therefore, based on guidelines and a review of the evidence, the request for MRI neck is not medically necessary.