

Case Number:	CM14-0032531		
Date Assigned:	06/20/2014	Date of Injury:	10/28/2011
Decision Date:	09/10/2014	UR Denial Date:	02/28/2014
Priority:	Standard	Application Received:	03/14/2014

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 Texas and Ohio. 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 42-year-old male with a reported date of injury on 10/28/2011. The mechanism of injury was not submitted within the medical record. His diagnoses were noted to include thoracolumbar spine strain, rule out herniated disc, bilateral carpal tunnel syndrome, and status post right ring finger fracture. His previous treatments were noted to include physical therapy, acupuncture, aquatic therapy, epidural injections, and medications. The progress note dated 11/20/2013 reveals the injured worker complained of frequent aching pain to his right wrist with weakness, numbness, and tingling. The pain became worse with repetitive use of the hand, and his pain decreased with rest and medications rated 2/10. The injured worker complained of popping and swelling to his right ring finger as well as weakness, numbness, and tingling. The injured worker rated the pain as 2/10. The injured worker complained of frequent aching pain to the left wrist and hand along with weakness, numbness, and tingling. The injured worker rated his pain as 2/10. The injured worker complained of intermittent middle and low back pain described as aching and stabbing with radiating pain to his left lower extremity. The injured worker rated his pain as 8/10. The physical examination of the cervical spine noted a negative Spurling's maneuver, no tenderness to palpation of the paraspinal musculature, and no complaint of increasing pain toward the terminal range of motion. There was a decreased range of motion noted. The bilateral shoulder inspection revealed full range of motion with no tenderness to palpation. The provocative testing was revealed to be negative. The bilateral elbow examination revealed full range of motion and no tenderness to palpation. The provocative testing to the bilateral elbows was negative. Physical examination of the bilateral wrists and hands noted full range of motion with no tenderness to palpation. There was no popping or triggering of the finger flexor tendons; however, there was positive Phalen's and Durkan's median compression test. The provider indicated the Katz hand diagram revealed classic pattern of bilateral carpal

tunnel syndrome. The thoracic spine examination revealed muscle guarding and spasming as well as decreased range of motion. There was paraspinal musculature tenderness to palpation. The lumbar spine examination revealed muscle guarding and spasming with decreased range of motion. There was a positive straight leg to the left side and tenderness to palpation of the paraspinal musculature. The bilateral hip examination revealed full range of motion, no tenderness to palpation, and the provocative testing was negative. The neurological examination revealed full motor strength rated 5/5, deep tendon reflexes brisk with no asymmetry, and sensory examination intact with no dermatomal deficits bilaterally. . The progress note dated 01/15/2014 reveals the injured worker reported decreased symptoms and had bilateral hand/wrist numbness and tingling, occasional right ring finger pain rated 7/10 with occasional mid and lower back pain rated 3/10. The physical examination revealed decreased grip strength and a frequent aching pain in the right wrist and hand, and a popping sensation and swelling in the right ring finger. The Request for Authorization form dated 12/27/2013 was for electromyography and nerve conduction velocity test to the bilateral upper and lower extremities to evaluate radiculopathy and confirm carpal tunnel syndrome. The Request for Authorization form dated 12/27/2013 was for a pain management consult; however, the provider's rationale was not submitted within the medical records. There was the request for the MRI for the lumbar spine, thoracic spine, and the pelvis was not submitted with the medical records and the provider's rationale was not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI OF THE LUMBAR SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The injured worker rated his low back pain as 3/10. The CA MTUS/ACOEM Guidelines state unequivocal objective findings that identify specific nerve compromise in the neurological examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminate imaging will result in both false positive findings, such as disc bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define potential cause, such as an MRI for neurological deficits. The guidelines state an MRI can be used to identify and define low back pathology in regard to disc protrusion, cauda equina syndrome, spinal stenosis, and postlaminectomy syndrome. There is a lack of documentation of a significant change in neurological deficits to warrant an MRI. Therefore, the request for an MRI of the lumbar spine is not medically necessary.

EMG UPPER EXTREMITIES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 3 OF 4.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

Decision rationale: The injured worker has been diagnosed with carpal tunnel syndrome. The CA MTUS/ACOEM Guidelines 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 and nerve conduction velocities, including H-reflex tests, may help identify subtle, focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than 3 to 4 weeks. The guidelines state the electromyography can be used to identify and define neck and upper back pathology in regard to identifying a physiological insult and identifying an anatomical defect. There was a lack of documentation showing significant neurological deficits such as decreased sensation motor strength or sensation in a specific dermatomal distribution to warrant an electromyography. The request for an electromyography of the upper extremities is not medically necessary. .

PAIN MANAGEMENT CONSULT FOR THORACOLUMBAR SPINE & BILATERAL UPPER EXTREMITIES: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 127.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: ACOEM 2nd Edition American College of Occupational and Environmental Medicine (ACOEM) Occupational Medical Practice Guidelines, Second Edition (2004), Chapter 6, page 163.

Decision rationale: The injured worker has had continuous pain to the right hand/wrist, right ring finger, and low back, as well as failure of conservative treatment. The ACOEM Guidelines state that if a diagnosis is uncertain or complex, if psychosocial factors are present, or if the plan or course of care may benefit from additional expertise, the occupational health physician may refer a patient to other specialist for an independent medical assessment. A consultation is intended to aid in assessing the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or examinee's fitness for return to work. A consultant is usually requested to act in an advisory capacity, but may sometimes take full responsibility for investigating and/or treating a patient within the doctor/patient relationship. The documentation indicates the injured worker has had failure of conservative treatment and continues to have pain despite measures taken. Therefore, the request for pain management consult for the thoracolumbar spine and bilateral upper extremities is medically necessary.

NCV Upper Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 3 of 4.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation The request for a NCV of the upper extremities is non-certified. The injured worker complains of frequent aching pain in his right wrist and hand. The Official Disability Guidelines do not recommend nerve conduction studies to demonstrate radiculopathy if radiculopathy has already been clearly identified by electromyography and obvious clinical signs, but recommended if the electromyography is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely in 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. While cervical electrodiagnostic studies are not necessary to demonstrate a cervical radiculopathy, they have been suggested to perform if brachial plexus abnormality, diabetic neuropathy, or some problem other than cervical radiculopathy, with caution that these can result in unnecessary over-treatment. The guidelines do recommend nerve conduction studies in patients with clinical signs of carpal tunnel syndrome who may be candidates for surgery. However, the injured worker has had previous nerve conduction studies of the upper extremities and there is a lack of clinical documentation to warrant a repeat study. Therefore, the request is non-certified.

Decision rationale: The injured worker complains of frequent aching pain in his right wrist and hand. The Official Disability Guidelines do not recommend nerve conduction studies to demonstrate radiculopathy if radiculopathy has already been clearly identified by electromyography and obvious clinical signs, but recommended if the electromyography is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely in 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. While cervical electrodiagnostic studies are not necessary to demonstrate a cervical radiculopathy, they have been suggested to perform if brachial plexus abnormality, diabetic neuropathy, or some problem other than cervical radiculopathy, with caution that these can result in unnecessary over-treatment. The guidelines do recommend nerve conduction studies in patients with clinical signs of carpal tunnel syndrome who may be candidates for surgery. However, the injured worker has had previous nerve conduction studies of the upper extremities and there is a lack of clinical documentation to warrant a repeat study. Therefore, The request for a NCV of the upper extremities is not medically necessary.

EMG Lower Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The injured worker has no evidence of radiculopathy. The CA MTUS/ACOEM Guidelines state that electromyography, including H-reflex test, may be used to identify subtle, focal neurological dysfunction in patients with low back symptoms lasting more than 3 to 4 weeks. The guidelines state that electromyography can be used to identify and define low back pathology such as disc protrusion, cauda equina syndrome, spinal stenosis, and postlaminectomy syndrome. There is a lack of documentation showing significant neurological deficits such as decreased motor strength or sensation in a specific dermatomal distribution to warrant an electromyography. Therefore, The request for an EMG of the lower extremities is not medically necessary.

NCV Lower Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Nerve Conduction Studies.

Decision rationale: The injured worker has had previous nerve conduction studies of the lower extremities. The Official Disability Guidelines do not recommend nerve conduction studies for there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. The systematic review and meta-analysis demonstrate that neurological testing procedures have limited overall diagnostic accuracy in detecting disc herniation with suspected radiculopathy. In the management of spine trauma with radicular symptoms, EMG/nerve conduction studies often have low combined sensitivity and specificity in confirming root injury, and there is limited evidence to support the use of often uncomfortable and costly EMG/NCS. There is a lack of documentation showing significant neurological deficits such as decreased motor strength or sensation in a specific dermatomal distribution to warrant a nerve conduction study. Therefore, The request for a NCV of the lower extremities is not medically necessary.

MRI OF THE THORACIC SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-179.

Decision rationale: The injured worker has had a previous MRI of the thoracic spine approximately 3 years ago. The CA MTUS/ACOEM Guidelines state physiologic evidence may be in the form of definite neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. The unequivocal findings that identify specific nerve compromise in the neurological 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 should be obtained before ordering an imaging study.

Electromyography and nerve conduction velocity including H-reflex tests can help identify subtle, focal neurological dysfunction in patients with neck or arm symptoms, or both, lasting more than 3 to 4 weeks. If physiologic evidence indicates tissue insult or nerve impairment, consider discussion with a consultant regarding the next steps, including the selection of an imaging test to define a potential cause, such as an MRI for a neurological issue. The recent evidence indicates cervical disc annular tears may be missed on MRIs. The guidelines state an MRI can be used to identify and define anatomical defects. There is a lack of documentation regarding a significant change in neurological deficits to warrant a repeat MRI. Therefore, the request for an MRI of the thoracic spine is not medically necessary.

MRI OF THE PELVIS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Hip and Pelvis, MRI.

Decision rationale: The injured worker has a lack of complaints regarding the hips or pelvis. The Official Disability Guidelines state an MRI is the most accepted form of imaging for finding avascular necrosis of the hip and osteonecrosis. The MRI is both highly sensitive and specific for detection of many abnormalities involving the hip or surrounding soft tissues and should in general be the first imaging technique employed following plain films. The guidelines' indications for MRI are osseous, articular, or soft tissue abnormalities, osteonecrosis, occult acute and stress fracture, acute and chronic soft tissue injuries, and tumors. There is a lack of documentation regarding clinical pathology with neurological deficits to warrant an MRI to the pelvis. Therefore, The request for an MRI of the pelvis is not medically necessary.