

Case Number:	CM14-0064251		
Date Assigned:	07/11/2014	Date of Injury:	10/04/2007
Decision Date:	09/18/2014	UR Denial Date:	04/09/2014
Priority:	Standard	Application Received:	05/07/2014

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 72-year-old female who reported an industrial injury on 10/4/2007, almost 7 years ago, attributed to the performance of her usual and customary job tasks. The patient complained of neck and wrist pain. The patient was authorized 2x4 sessions of physical therapy and a right wrist brace. The patient complained of constant neck pain and numbness. The objective findings on physical examination included tenderness about the cervical and lumbar spine with spasm; positive SLR and Spurling's test; positive Tinel's and Phalen's sign; decreased sensation in the digits. Patient was diagnosed with cervicgia and bilateral wrist pain. The treatment plan included a MRI of the bilateral wrists; EMG/NCS of the bilateral upper extremities; and cervical spine MRI.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI BILATERAL WRISTS HANDS: 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) Section forearm, wrist, and hand chapter-MRI; carpal tunnel syndrome chapter-MRI.

Decision rationale: The request for the MRI of the bilateral wrists was not supported with objective evidence to support medical necessity for the effects of the cited industrial injury. The requested a MRI of the bilateral wrist 7 years after the date of injury directed to the diagnosis of wrist sprain, which is documented to be improving is not demonstrated to be medically necessary. The MRI of the bilateral wrist was ordered to rule out a ligamentous tear. The patient has not been prescribed PT/OT and has not been demonstrated to have failed conservative care. The MRI is ordered as a screening examination to rule out "pathology" without the documentation of objective findings on examination to support medical necessity. There was no objective evidence documented to support medical necessity for an MRI of the wrist. The MRI was not ordered by a Hand Surgeon contemplating surgical intervention. There is no specific diagnosis provided to the right hand/wrist other than a "sprain." The request for a MRI was not supported by documented objective findings on examination. There are no objective findings on examination to support the medical necessity of the requested MRI study and no objective findings consistent with a TFCC tear or a ligament tear consistent with the cited mechanism of injury. The MRI was being used as a screening tool. The patient is reporting persistent pain; however, there is no evidence of participation in HEP. The treatment plan for the patient is not demonstrated to be based on the results of the MRI. There was no documentation of the failure of conservative care. There is no documentation of possible triangular fibrocartilage (TFCC) and intraosseous ligament tears, occult fractures, or avascular neurosis to support the medical necessity of a MRI of the bilateral wrist. The provided diagnoses do not support the medical necessity of the requested MRI of the wrist or hand other than the screening for the possibility of a TFCC tear with no objective findings on examination. There is no demonstrated medical necessity for the requested MRIs of the bilateral wrists as screening studies.

EMG/NCS BILATERAL UPPER EXTREMITIES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

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

Decision rationale: The request for the authorization of the EMG/NCS of the bilateral upper extremities 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 continued left elbow pain that was diagnosed as a sprain/strain and left elbow medial/lateral epicondylitis. 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 EMG/NCS screening examination. 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. 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 an EMG/NCS/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 CERVICAL 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): 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 7 years 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 imaging studies. The patient was documented to have been provided 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 is no demonstrated ongoing conservative

care to the cervical spine and there are no documented neurological deficits progressing. 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.