

Case Number:	CM14-0072441		
Date Assigned:	07/16/2014	Date of Injury:	10/10/2011
Decision Date:	09/08/2014	UR Denial Date:	04/18/2014
Priority:	Standard	Application Received:	05/19/2014

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 Orthopaedic Surgery 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 49-year-old male laborer sustained an industrial injury on 10/10/11. Injury occurred when he fell off a ladder from about 4 or 5 feet high while sawing pieces of lumbar. The 2/12/13 right wrist MRI impression documented findings of ulnocarpal abutment syndrome, eccentric proximal lunate edema/sclerosis/cyst, and mild positive ulnar variance. There were triangular fibrocartilage and scapholunate tears. There was mild separation of the scaphoid and lunate in the coronal plane. No dorsal intercalated segment instability (DISI) deformity was noted. There was small wrist effusion and small radioulnar effusion. The 2/6/13 left shoulder MRI documented no rotator cuff tear or marked tendinosis noted, intact glenohumeral joint, and small amount of glenohumeral fluid. There was a type II acromion with mild lateral downsloping, thickening of the acromioclavicular joint with inferior spurring, and no marked outlet obstruction. The 12/12/13 cervical MRI documented mild cervical spondylosis with no focal protrusion or extrusion. There was no canal or foraminal stenosis. There was an annular bulge at C4/5 with posterior central small annular tear. The 2/6/13 lumbar spine MRI demonstrated L3/4 anterolisthesis with disc protrusion mildly impressing the ventral thecal sac without canal stenosis. There were disc bulges at L1/2, L2/3, L3/4, and L5/S1 without canal or foraminal stenosis. The 3/19/14 treating physician report cited continued grade 4/10 left lateral neck and bilateral shoulder pain radiating to the right wrist, and hand pain with motion. He also complained of low back and bilateral hip pain increased with walking or lying down. He had not had any physical therapy for the neck or low back, only the hand. Orphenadrine and Norco were controlling his symptoms. Physical exam documented mild cervical paraspinal tenderness, antalgic gait, diffuse cervicothoracic and trapezius tenderness, and limited cervical flexion. There was lumbar paraspinal tenderness, marked bilateral trochanteric bursa pain, and decreased lumbar exercise and lateral bending. Right wrist was tender with positive Finkelstein's test. Grip

strength was markedly diminished on the right. The diagnosis was left shoulder pain, cervical pain, lumbago, right wrist/forearm pain, hip/pelvic pain, and trochanteric bursitis. Medications were prescribed and physical therapy was recommended for the neck and lower back. The 3/18/13 DWC form requested right wrist MRI, hand orthopedic consult, right upper extremity Electromyography (EMG), left shoulder MRI, and left lower extremity EMG. The 4/18/14 utilization review denied the request for right wrist MRI as there was no substantial change or worsening of the patient's condition since the prior MRI to support the medically necessary. The request for right upper extremity EMG/ Nerve conduction velocity (NCV) was denied as there were no clinical findings suggestive of cervical radiculopathy or peripheral neuropathy to support the medical necessity. A request for right hand orthopedic consult was certified. The request for left lower extremity EMG/NCV was denied as there were no clinical findings suggestive of lumbar radiculopathy or peripheral neuropathy to support the medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI Right Wrist: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Forearm, Wrist, & Hand Chapter; MRI's (magnetic resonance imaging).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-269. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist and Hand, MRIs (magnetic resonance imaging).

Decision rationale: The California Medical Treatment Utilization Schedule does not provide criteria for repeat wrist MRIs. The Official Disability Guidelines state that repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. Guideline criteria have not been met. There is no current indication of a significant change in symptoms to support the medical necessity of repeat imaging. Therefore, this request for MRI of the right wrist is not medically necessary.

EMG Right Upper Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 177-178, 261. Decision based on Non-MTUS Citation Official Disability Guidelines: Electrodiagnostic testing (EMG/NCS) Upper Extremities.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179, 213.

Decision rationale: The California MTUS states that EMG is not recommended as a part of a shoulder evaluation for usual diagnoses. Guidelines state that EMG is not recommended for diagnosis of cervical nerve root involvement if findings or history, physical exam, and imaging study are consistent. EMG is recommended to clarify nerve root dysfunction in cases of

suspected disc herniation pre-operatively or before epidural injection. Guideline criteria have not been met. There is no specific rationale to support the medical necessity of electrodiagnostic testing in the right upper extremity. A focal neurologic deficit is not documented. There are no clinical exam findings suggestive of radiculopathy or neuropathy. Therefore, this request for EMG right shoulder is not medically necessary.

NCS Right Upper Extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 177-178, 261. Decision based on Non-MTUS Citation Official Disability Guidelines: Electrodiagnostic testing (EMG/NCS) Upper Extremities.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179, 213.

Decision rationale: The California MTUS states that NCV is not recommended as a part of a shoulder evaluation for usual diagnoses. Guidelines state that EMG and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurological dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. Guideline criteria have not been met. There is no specific rationale to support the medical necessity of electrodiagnostic testing in the right upper extremity. A focal neurologic deficit is not documented. There are no clinical exam findings suggestive of radiculopathy or neuropathy. Therefore, this request for nerve conduction study of the right shoulder is not medically necessary.

MRI Left Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 207, 208. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder Chapter; Magnetic resonance imaging (MRI).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208-209. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Magnetic resonance imaging (MRI).

Decision rationale: The California Medical Treatment Utilization Schedule does not address criteria for repeat shoulder MRIs. The Official Disability Guidelines state that repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. Guideline criteria have not been met. A left shoulder MRI was performed on 2/3/13. There is no current indication of a significant change in symptoms to support the medical necessity of repeat imaging. Therefore, this request for MRI of the right wrist is not medically necessary.

EMG Left Lower Extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303, 309. Decision based on Non-MTUS Citation Ortiz-Corredor F. Clinical examination and electromyographic abnormalities in patients with lower back pain. Rev Neurol.2003. July 16-31;37(2): 106-11.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 62-63. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

Decision rationale: The California MTUS ACOEM guidelines state that EMG may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than 3 to 4 weeks. Guideline criteria have not been met. There is no current clinical exam suggestive of lumbar radiculopathy. There is no imaging evidence of nerve root compromise. There is no documentation of left lower extremity symptoms or exam findings suggestive of radiculopathy or neuropathy. Therefore, this request for EMG left lower extremity is not medically necessary.

NCS Left Lower Extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303,309. Decision based on Non-MTUS Citation Ortiz-Corredor F. Clinical examination and electromyographic abnormalities in patients with lower back pain. Rev Neurol.2003. July 16-31;37(2): 106-11.

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 - Lumbar & Thoracic, Nerve conduction studies (NCS).

Decision rationale: The California MTUS does not provide criteria for nerve conduction studies in the lower extremities. The Official Disability Guidelines do not recommend nerve conduction studies in the lower extremities. Guideline criteria have not been met. There is no current clinical exam suggestive of lumbar radiculopathy. There is no imaging evidence of nerve root compromise. There is no documentation of left lower extremity symptoms or exam findings suggestive of radiculopathy or neuropathy. Therefore, this request for nerve conduction study of the left lower extremity is not medically necessary.