

Case Number:	CM14-0187944		
Date Assigned:	11/18/2014	Date of Injury:	04/04/2014
Decision Date:	01/06/2015	UR Denial Date:	11/03/2014
Priority:	Standard	Application Received:	11/11/2014

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 Internal Medicine and is licensed to practice in New York. 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 patient is a 41 year old female machine operator with a date of injury of 04/04/2014. Her last day of work was 04/24/2014. She accidentally started a printing machine that she operates and the printing arms struck her head, shoulders and back. X-rays were negative. She had head, spine, arm and leg pain. She had physical therapy and chiropractic care. On 05/09/2014 most of her pain was from her neck. Then back pain and finally shoulder pain. The neck and back pain was 6/10. She had decreased neck and back range of motion. Sensory exam was normal. Reflexes were normal. Motor exam was 4/5 to 4+/5. The listed diagnosis was cervical radiculopathy, cervical, thoracic and lumbar sprain/strain, shoulder arthralgia and wrist/hand arthralgia. The picture chart of numbness and tingling was not consistent with cervical radiculopathy. On 05/20/2014 she had an orthopedic consultation with [REDACTED]. The impression was right and left shoulder bursitis with AC joint arthritis. There was no examination of the neck or back. Physical therapy was prescribed. On 06/04/2014 and 06/06/2014 she had another chiropractor visit. She had ultrasound of both shoulders. She also had therapeutic exercise physical therapy. She had multiple visits to the [REDACTED]. On 06/09/2014 she had bilateral upper extremity EMG/NCS that was normal. She did not have cervical radiculopathy or carpal tunnel syndrome. By 06/12/2014 she had completed 4 physical therapy visits and 5 chiropractic visits which also included physical therapy. She had an office visit with [REDACTED] also at the [REDACTED]. On 07/01/2014 and 08/12/2014 she again had an office visit at the [REDACTED] with [REDACTED]. On 07/17/2014, on 08/28/2014 and on 09/22/2014 she had another orthopedic office visit with [REDACTED] who noted cervical radiculopathy despite the normal EMG/NCS. On 09/23/2014 she had an evaluation by [REDACTED] and had a listed diagnosis of bilateral shoulder impingement

and bursitis, cervical radiculopathy, bilateral AC joint mild arthritis and cervical, thoracic and lumbar strain/sprain.

IMR ISSUES, DECISIONS AND RATIONALES

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

General orthopedic follow ups with [REDACTED] (shoulder, wrist, hand): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Office Visits

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Campbell's Operative Orthopaedics, 12th Edition. 2013

Decision rationale: California Medical Treatment Utilization Schedule (MTUS) and Official Disability Guidelines (ODG) are silent on this. This patient has already had multiple orthopedic office visits by this orthopedist and another orthopedist. Despite a normal bilateral upper extremity EMG/NCS and tingling and numbness complaints that are not consistent with cervical radiculopathy, orthopedic surgeons at the [REDACTED] continue to list cervical radiculopathy as a diagnosis. She already had multiple orthopedic visits with this orthopedist and another one at the [REDACTED]. There is insufficient documentation to substantiate the continued follow up with multiple orthopedists at the same practice.

MRI cervical: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back Chapter, Low Back Chapter, Indications for Imaging

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 165-188.

Decision rationale: She does not have cervical radiculopathy as the bilateral upper extremity Electromyography (EMG), and nerve conduction velocities (NCV) were normal. Criteria for cervical imaging studies include: Red flag signs physiologic evidence of tissue insult or neurologic dysfunction - Failure to progress in a strengthening program intended to avoid surgery - Clarification of the anatomy prior to an invasive procedure 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. (EMG), and (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. The assessment may include sensory-evoked potentials (SEPs) if spinal stenosis or spinal cord

myelopathy is suspected. If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps, including the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, compute tomography [CT] for bony structures). Additional studies may be considered to further define problem areas. The recent evidence indicates cervical disk annular tears may be missed on MRIs. The clinical significance of such a finding is unclear, as it may not correlate temporally or anatomically with symptoms. In the following circumstances, an imaging study may be appropriate for a patient whose limitations due to consistent symptoms have persisted for four to six weeks or more: - When surgery is being considered for a specific anatomic defect - To further evaluate the possibility of potentially serious pathology, such as a tumor Reliance on imaging studies alone to evaluate the source of neck or upper back symptoms carries a significant risk of diagnostic confusion (false-positive test results) because it's possible to identify a finding that was present before symptoms began. The patient does not meet the above criteria. There is no documentation that the patient is a surgical candidate.

Chiropractic 8 visits for the cervical, lumbar, upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The patient already had 5 chiropractic visits and 4 additional physical therapy visits. California Medical Treatment Utilization Schedule (MTUS) and Official Disability Guidelines (ODG) note a maximum number of physical medicine visits of 8 - 10 visits for strain/sprains and for chronic pain. There is no documentation that the previous chiropractic visits with ultrasound was associated with any functional improvement. The requested additional 8 chiropractic visits are not consistent with California MTUS guidelines.

Follow up with [REDACTED]: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Office Visits

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Campbell's Operative Orthopaedics, 12th Edition. 2013

Decision rationale: California Medical Treatment Utilization Schedule (MTUS) and Official Disability Guidelines (ODG), Pain Chapter, Office Visits. ODG are silent on this. This patient has already had multiple orthopedic office visits by this orthopedist and another orthopedist. Despite a normal bilateral upper extremity EMG/NCS and tingling and numbness complaints that are not consistent with cervical radiculopathy, orthopedic surgeons at the [REDACTED] [REDACTED] continue to list cervical radiculopathy as a diagnosis. She already had multiple orthopedic visits with this orthopedist and another one at the [REDACTED]. There

is insufficient documentation to substantiate the continued follow up with multiple orthopedists at the same practice.

MRI lumbar: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back Chapter, Low Back Chapter, Indications for Imaging

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-316.

Decision rationale: Based on the California Medical Treatment Utilization Schedule (MTUS), American College of Occupational Environmental Medicine (ACOEM) Chapter 12 page 303 notes "Lumbar spine x rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. However, it may be appropriate when the physician believes it would aid in patient management. Unequivocal objective findings that identify specific nerve compromise on the neurologic 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. In discriminant imaging will result in false-positive findings, such as disk 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 a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computed tomography [CT] for bony structures). Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. Discography is not recommended for assessing patients with acute low back symptoms. Low Back Complaints 303 There is not documentation that the patient is a surgical candidate and she does not meet the above criteria.

MRI thoracic: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back Chapter, Low Back Chapter, Indications for Imaging

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 165-186.

Decision rationale: She does not have cervical radiculopathy or thoracic radiculopathy, NCS/EMG was normal. Criteria for cervical imaging studies include: Red flag signs: Physiologic evidence of tissue insult or neurologic dysfunction - Failure to progress in a strengthening program intended to avoid surgery - Clarification of the anatomy prior to an invasive procedure 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 (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. The assessment may include sensory-evoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected. If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps, including the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, compute tomography [CT] for bony structures). Additional studies may be considered to further define problem areas. The recent evidence indicates cervical disk annular tears may be missed on MRIs. The clinical significance of such a finding is unclear, as it may not correlate temporally or anatomically with symptoms. In the following circumstances, an imaging study may be appropriate for a patient whose limitations due to consistent symptoms have persisted for four to six weeks or more: - When surgery is being considered for a specific anatomic defect - To further evaluate the possibility of potentially serious pathology, such as a tumor Reliance on imaging studies alone to evaluate the source of neck or upper back symptoms carries a significant risk of diagnostic confusion (false-positive test results) because it's possible to identify a finding that was present before symptoms began. The patient does not meet the above criteria. There is no documentation that the patient is a surgical candidate.