Case Number:	CM14-0194949		
Date Assigned:	12/02/2014	**Date of Injury:**	08/13/2003
Decision Date:	01/14/2015	**UR Denial Date:**	11/03/2014
Priority:	Standard	**Application Received:**	11/20/2014

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 New Jersey. 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 37-year-old female who reported injury on 08/13/2013. The mechanism of injury was not submitted for review. The injured worker has diagnoses of impingement syndrome of the shoulder on the right with bicipital tendonitis, cubital tunnel on the right, stenosis tenosynovitis along the first extensor on the right, discogenic cervical condition for which no treatment has been provided, CMC (carpometacarpal) joint inflammation of the thumb on the right, numbness in the left upper extremity and element of depression. Past medical treatment consists of cognitive behavioral therapy, modified duty, acupuncture, physical therapy, use of a TENS unit, splints, biofeedback, cortisone injections, psychotherapy, ice, chiropractic therapy, the use of a hinged elbow brace, the use of a thumb Spica splint and medication therapy. Medications consist of Flexeril, Nalfon, tramadol, Protonix, Lidopro cream, and trazodone. The injured worker has undergone right shoulder arthroscopy and rotator cuff repair on 06/28/2010, right first extensor release on 11/09/2011, and right ulnar nerve release and epicondylectomy on 12/09/2013. Diagnostics include x-rays of the right shoulder, which revealed excellent decompression and evidence of osteoarthritis; x-rays of the elbows, which revealed minimal degenerative changes; x-rays of the wrist and hands, which were normal; fluoroscopy examination of the shoulder, which revealed no calcific lesions; and an EMG/NCS of the right elbow, which revealed mild cubital tunnel syndrome. On 10/09/2014, the injured worker complained of neck and right upper extremity pain. She stated to have some numbness and tingling on the left arm, and some limitation with pinching and torqueing, but no major function limitation of the left arm. Physical examination revealed tenderness along the rotator cuff, the lateral epicondyle, the first extensor and the base of the thumb. Range of motion was reduced along the shoulder, with weakness of a grip. Treatment plan is for the injured worker to undergo

MRI of the neck and EMG/NCS of the upper extremities bilaterally. The rationale and Request for Authorization form were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of Neck: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

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

Decision rationale: The request for an MRI of the neck is not medically necessary. According to the California MTUS criteria for ordering imaging studies include emergence of red flag, physiological evidence of tissue insult or a neurologic dysfunction, failure to progress in the strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with the consultant regarding next steps, including the selection of an imaging test to define a potential cause (magnetic resonance imaging for neural or other soft tissue, computed tomography for bony structures). Additional studies may be considered to further define problem areas. The recent evidence indicates cervical disc annular tears may be missed on MRIs. The clinical significance of such a finding is unclear, as it may not correlate temporarily or anatomically with symptoms. The submitted documentation indicated that the injured worker had failed conservative treatment. It was also noted on progress note dated 10/09/2014 that the injured worker had tenderness along the rotator cuff, lateral epicondyle, the first extensor and the base of the thumb. It was also documented that range of motion was reduced along the shoulder. However, there were no pertinent functional deficits associated with the injured worker's neck documented on the report. Furthermore, submitted documentation did not indicate any emergence of red flag, nor was there any indication of the provider needing clarification of the anatomy prior to an invasive procedure. Given the above, the injured worker is not within the MTUS/ACOEM guideline criteria. As such, the request is not medically necessary.

EMG Right Upper Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

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

Decision rationale: The request for EMG right upper extremities is not medically necessary. According to the California MTUS criteria for ordering imaging studies include emergence of red flag, physiological evidence of tissue insult or a neurologic dysfunction, failure to progress in the strengthening program intended to avoid surgery, and 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. The submitted documentation indicated that the injured worker had failed conservative treatment. It was also noted on progress note dated 10/09/2014 that the injured worker had tenderness along the rotator cuff, lateral epicondyle, the first extensor and the base of the thumb. It was also documented that range of motion was reduced along the shoulder. However, there were no numbered range of motion measurements documented on the report. Additionally, there were no sensory deficits submitted for review indicating any specific nerve compromise. Furthermore, submitted documentation did not indicate any emergence of red flag, nor was there any indication of the provider needing clarification of the anatomy prior to an invasive procedure. Given the above, the injured worker is not within the MTUS/ACOEM guideline criteria. As such, the request is not medically necessary.

NCS Right Upper Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

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

Decision rationale: The request for an NCS right upper extremities is not medically necessary. According to the California MTUS criteria for ordering imaging studies include emergence of red flag, physiological evidence of tissue insult or a neurologic dysfunction, failure to progress in the strengthening program intended to avoid surgery, and 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. The submitted documentation indicated that the injured worker had failed conservative treatment. It was also noted on progress note dated 10/09/2014 that the injured worker had tenderness along the rotator cuff, lateral epicondyle, the first extensor and the base of the thumb. It was also documented that range of motion was reduced along the shoulder. However, there were no numbered range of motion measurements documented on the report.

Additionally, there were no sensory deficits submitted for review indicating any specific nerve compromise. Furthermore, submitted documentation did not indicate any emergence of red flag, nor was there any indication of the provider needing clarification of the anatomy prior to an invasive procedure. Given the above, the injured worker is not within the MTUS/ACOEM guideline criteria. As such, the request is not medically necessary.

EMG Left Upper Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

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

Decision rationale: The request for EMG left upper extremities is not medically necessary. According to the California MTUS criteria for ordering imaging studies include emergence of red flag, physiological evidence of tissue insult or a neurologic dysfunction, failure to progress in the strengthening program intended to avoid surgery, and 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. The submitted documentation indicated that the injured worker had failed conservative treatment. It was also noted on progress note dated 10/09/2014 that the injured worker had tenderness along the rotator cuff, lateral epicondyle, the first extensor and the base of the thumb. It was also documented that range of motion was reduced along the shoulder. However, there were no numbered range of motion measurements documented on the report. Additionally, there were no sensory deficits submitted for review indicating any specific nerve compromise. Furthermore, submitted documentation did not indicate any emergence of red flag, nor was there any indication of the provider needing clarification of the anatomy prior to an invasive procedure. Given the above, the injured worker is not within the MTUS/ACOEM guideline criteria. As such, the request is not medically necessary.

NCS Left Upper Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

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

Decision rationale: The request for NCS left upper extremities is not medically necessary. According to the California MTUS criteria for ordering imaging studies include emergence of red flag, physiological evidence of tissue insult or a neurologic dysfunction, failure to progress in the strengthening program intended to avoid surgery, and 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. The submitted documentation indicated that the injured worker had failed conservative treatment. It was also noted on progress note dated 10/09/2014 that the injured worker had tenderness along the rotator cuff, lateral epicondyle, the first extensor and the base of the thumb. It was also documented that range of motion was reduced along the shoulder. However, there were no numbered range of motion measurements documented on the report. Additionally, there were no sensory deficits submitted for review indicating any specific nerve compromise. Furthermore, submitted documentation did not indicate any emergence of red flag, nor was there any indication of the provider needing clarification of the anatomy prior to an invasive procedure. Given the above, the injured worker is not within the MTUS/ACOEM guideline criteria. As such, the request is not medically necessary.