

<b>Case Number:</b>	CM14-0206536		
<b>Date Assigned:</b>	12/18/2014	<b>Date of Injury:</b>	06/16/2014
<b>Decision Date:</b>	02/23/2015	<b>UR Denial Date:</b>	11/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/09/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: District of Columbia, Virginia  
 Certification(s)/Specialty: Internal Medicine

### 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 42 year old patient who sustained injury on Jun 16 2014. She was diagnosed with chronic cervicgia, bilateral shoulder and wrist region arthralgia, recurrent myofascial strain, bilateral carpal tunnel syndrome and impingement shoulder syndrome . The patient had ongoing pain issues of the upper extremities , involvig the neck, shoulder, low back region and wrist/hands. Mulitple studies were ordered including xrays, EMG/NCV as well as physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**X-Ray of the bilateral wrists and bilateral shoulder:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Wrist and shoulder radiography.

**Decision rationale:** MTUS and ACOEM would not be indicated. Per ODG guidelines, this patient would not meet criteria for which these interventions would be indicated. Shoulder radiography: Recommended as indicated below. The acutely traumatized shoulder should be imaged with plain films that are orthogonal to each other. Shoulder arthrography is still the imaging 'gold standard' as it applies to full-thickness rotator cuff tears, with over 99 percent accuracy, but this technique must be learned so it is not always recommended (Newberg, 2000). Plain radiographs should be routinely ordered for patients with chronic shoulder pain, including anteroposterior osteoarthritis of this joint is common by the age of 40 to 50 years. The preferred imaging modality for patients with suspected rotator cuff disorders is MRI. However, ultrasonography may emerge as a cost effective alternative to MRI. (Burbank 2008) Indications for imaging-Plain radiographs:-acute shoulder trauma, rule out fracture or dislocation-acute shoulder trauma, questionable bursitis, blood calcium (Ca<sup>++</sup>)/approximately 3 months duration, first study Indications for imaging: X rays-acute hand or wrist trauma, first exam-acute hand or wrist trauma, suspect acute scaphoid fracture, first exam, plus cast and repeat radiographs in 10-14 days-acute hand or wrist trauma, suspect distal radioulnar joint subluxation-acute hand or wrist trauma, suspect hook of the hamate fracture-acute hand or wrist trauma, suspect metacarpal fracture or dislocation-acute hand or wrist trauma, suspect phalangeal fracture or dislocation-acute hand or wrist trauma, suspect thumb fracture or dislocation-acute hand or wrist trauma, suspect gamekeeper injury (thumb MCP ulnar collateral injury)-chronic wrist pain, first study obtained in patient with chronic wrist pain with or without prior injury, no specific area of pain specified.

**Physical therapy 3x4 weeks for the bilateral wrists and the bilateral shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99.

**Decision rationale:** Per MTUS guidelines and based on the clinical data provided, there is no evidence that the patient has radiculopathy and the number of physical therapy visits would not be indicated. Physical Medicine Guidelines Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks.

**EMG/NCV of bilateral upper extremities:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178, 182.

**Decision rationale:** For most patients presenting with true neck or upper back problems, special studies are not needed unless a three- or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out. Criteria for ordering imaging studies are: - Emergence of a red flag- 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.