Case Number:	CM15-0105720		
Date Assigned:	06/08/2015	**Date of Injury:**	05/17/2014
Decision Date:	07/08/2015	**UR Denial Date:**	05/15/2015
Priority:	Standard	**Application Received:**	05/29/2015

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: California, Indiana, New York
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:

The injured worker is a 59 year old female, who sustained an industrial injury on 5/17/14. She reported initial complaints of a fall resulting in pain in her left shoulder, arm and wrist/hand and low back. The injured worker was diagnosed as having spondylosis lumbar; degenerative disc disease lumbar; herniated disc lumbar; stenosis lumbar; fracture-lumbar. Treatment to date has included physical therapy; medications. Diagnostics included MRI lumbar spine (9/27/14). Currently, the PR-2 notes dated 4/30/15 indicated the injured worker complains of neck pain intermittent slight to moderate with radiation to the left upper arm. The left shoulder has intermittent moderate pain aggravated by reaching overhead, lifting, carrying, pushing, pulling and increased use of the left upper extremity. She has popping and clicking in the left shoulder and numbness in the left hand. She also complains of the right shoulder due to favoring her left. The left wrist/hand is painful intermittently as moderate and aggravated by gripping, grasping, writing, using scissors, design tools, lifting, carrying with numbness and tingling in the left wrist and hand. He low back has intermittent moderate low back pain radiating to both legs. She has numbness and tingling in both legs with pain levels at 6-7/10. The documentation notes the injured worker relates to a pre-existing condition of Rheumatoid arthritis that has worsened since her accident of 5/17/14. She is currently taking Prednisone, Advil and Motrin. The physical examination notes the tenderness and muscle spasm noted. The left elbow notes tenderness to palpation along the medical and lateral olecranon. Tennis elbow test is negative. The left wrist/hand exam notes tenderness to palpation along the DRUJ and styloid of radius and ulna bilaterally. There is no crepitus; intact sensibility with good capillary refill. There are Negative

Tinel's, Phalen's and Finkelstein's test and Guyon's canal; negative Durkan's sign to wrist. The lumbar spine notes increased tone and tenderness about the paralumbar musculature with tenderness at the midline thoraco-lumbar junction and over the level of the L5-S1 facets and right greater sciatic notch; there are muscle spasms. A MRI lumbar spine dated 9/27/14 impression is noted as L5-S1 a 4-5mm left paracentral and lateral recess extrusion with caudal extent which moderately impinges the left S1 budding nerve root in the left lateral recess. There is no overall canal stenosis; and there is discogenic disease at L3-4 and L4-5 without significant canal or foraminal stenosis. The provider's treatment plan includes a request for physical therapy. He has also requested an EMG/NCV bilateral upper extremities and Bone Density lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV Bilateral Upper Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck section, EMG/NCV.

Decision rationale: Pursuant to the Official Disability Guidelines, EMG/NCV of the bilateral upper extremities are not medically necessary. The ACOEM states (chapter 8 page 178) unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging 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. Nerve conduction studies are not recommended to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but recommended if the EMG is not clearly radiculopathy or clearly negative or to differentiate radiculopathy from other neuropathies or non-neuropathies if other diagnoses may be likely based on physical examination. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy. While cervical electrodiagnostic studies are not necessary to demonstrate his cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality, diabetic property or some problem other than cervical radiculopathy. In this case, the injured worker's working diagnoses are cervical spine sprain strain with radicular components; left shoulder rotator cuff tendinitis/bursitis; history left proximal humerus fracture; left wrist contusion; lumbar spine sprain strain with radicular complaints. The date of injury is May 17, 2014. Subjectively, according to an April 30, 2015 progress note, the injured worker has neck pain that radiates to the left upper extremity. There are no subjective symptoms involving the right upper extremity. The injured worker sustained a slip and fall with fractures to the left shoulder and wrist. According to a September 14, 2014 progress note, the injured worker has low back pain with a fractured disk compressing the sciatic nerve. The injured worker received physical therapy with relief. Objectively, there was tenderness palpation over the lumbar spine with decreased range of motion. There were no neurologic findings or objective evidence of

radiculopathy involving the right or left upper extremities. There are no unequivocal clinical findings that identify specific nerve compromise on the neurologic evaluation. Consequently, absent clinical documentation with objective evidence of radiculopathy in the right and left upper extremities on neurologic evaluation and unequivocal clinical findings and identify specific nerve compromise on neurologic evaluation, EMG/NCV of the bilateral upper extremities are not medically necessary.

Bone Density Lumbar Spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Radiology.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://www.aetna.com/cpb/ medical/data/ 100_199/0134.html.

Decision rationale: Pursuant to the Aetna Clinical Policy Bulletin #0134, bone density lumbar spine is not medically necessary. Aetna considers bone mass measurement medically necessary for those who meet the following criteria. Individuals being monitored to assess response to or efficacy of osteoporosis drug therapy; individuals receiving the glucocorticoid therapy; individuals with celiac sprue; primary hyperparathyroidism individuals with vertebral abnormalities demonstrated by x-ray indicative of osteoporosis, osteopenia or vertebral fracture; or men greater than 50 with specific risk factors for osteoporosis; etc. See the attached link for additional details. Aetna considers bone mass measurement experimental and investigational for all other indications because it's effectiveness of than the ones listed (see above) have not been established. In this case, the injured worker's working diagnoses are cervical spine sprain strain with radicular components; left shoulder rotator cuff tendinitis/bursitis; history left proximal humerus fracture; left wrist contusion; lumbar spine sprain strain with radicular complaints. The date of injury is May 17, 2014. Subjectively, according to an April 30, 2015 progress note, the injured worker has neck pain that radiates to the left upper extremity. There are no subjective symptoms involving the right upper extremity. The injured worker sustained a slip and fall with fractures to the left shoulder and wrist. According to a September 14, 2014 progress note, the injured worker has low back pain with a fractured disk compressing the sciatic nerve. The injured worker received physical therapy with relief. Objectively, there was tenderness palpation over the lumbar spine with decreased range of motion. There were no neurologic findings or objective evidence of radiculopathy involving the right or left upper extremities. The worker has a history of rheumatoid arthritis. There was no radiographic evidence of osteoporosis documented in the medical record. Bone density scanning accurately measures bone mass or predicts fracture risk. Although the injured worker has a history of rheumatoid arthritis and takes glucocorticoids, the treating provider is not provided a clinical rationale for this diagnostic study in the injured worker with a long-standing history of rheumatoid arthritis. Consequently, absent clinical documentation with the clinical rationale for a bone density scan in an injured worker with long-standing rheumatoid arthritis who sustained a slip and fall with fractures, bone density lumbar spine is not medically necessary.