MAXIMUS Federal Services

Case Number:	CM15-0106982		
Date Assigned:	06/11/2015	Date of Injury:	04/03/2013
Decision Date:	07/13/2015	UR Denial Date:	05/26/2015
Priority:	Standard	Application Received:	06/03/2015

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 58 year old female, who sustained an industrial injury on 04/03/2013. She reported gradual complaints of pain along with numbness and tingling to the right wrist and hand secondary to work activities. The injured worker was diagnosed as having chronic cervical strain with rule out disc herniation, chronic lumbar strain with rule out disc herniation, bilateral hand first carpometacarpal joint arthritis, bilateral carpal tunnel syndrome, and status post carpal tunnel release of the right wrist. Treatment and diagnostic studies to date has included physical therapy, medication regimen, nerve conduction study of the upper extremities, physical therapy, status post carpal tunnel release, and x-rays of the bilateral hands on 04/09/2015. X-rays on the bilateral hands performed on 04/09/2015 were revealing for first carpometacarpal degenerative changes. In a progress note dated 04/09/2015 the treating physician reports complaints of constant neck pain that radiates to the shoulders into the hands with associated symptoms of numbness and tingling in the hands with the left greater than the right and headaches. The injured worker reported constant pain to the bilateral shoulders with associated symptoms of clicking, popping, numbness and tingling, and burning sensations. The treating physician also noted complaints of constant bilateral hand and wrist pain with associated symptoms of numbness and tingling to the left hand into the fingers with a loss of grip and a loss of sensation. The injured worker also has complaints of frequent low back pain that radiates to the hips and into the bilateral lower extremities. Examination reveals decreased range of motion to the cervical spine, tenderness and hypertonicity to the trapezius muscles, positive compression test and Spurling's test to the cervical spine, positive impingement tests to the bilateral shoulders, decrease muscle strength to the shoulders, positive Tinel's sign bilaterally

to the medial nerve, decreased sensation to the median nerve, decreased range of motion to the lumbar spine, tenderness over the lumbar paraspinal muscles and quadratus lumborum muscles bilaterally, and hypertonicity to the lumbar paraspinal muscles. The treating physician requested magnetic resonance imaging of the cervical and lumbar spine to rule out disc herniations and an electromyogram with nerve conduction velocity of the bilateral lower extremities to evaluate for right lower extremity radicular pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the cervical spine: 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): 178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck section, MRI cervical spine.

Decision rationale: Pursuant to the ACOEM and the Official Disability Guidelines, MRI cervical spine is not medically necessary. ACOEM states unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients not respond to treatment and who would consider surgery an option. Patients who are alert, have never lost consciousness, are not under the influence of alcohol and/or drugs, have no distracting injuries, have no cervical tenderness with no neurologic findings do not need imaging. Patients who do not fall into this category should have a three view cervical radiographic series followed by a computer tomography (CT). The indications for imaging are enumerated in the Official Disability Guidelines. Indications include, but are not limited to, chronic neck pain (after three months conservative treatment), radiographs normal neurologic signs or symptoms present; neck pain with radiculopathy if severe or progressive neurologic deficit; etc. Repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, and recurrent disc herniation). The criteria for ordering an MRI of the cervical spine include the emergence of a red flag, physiologic evidence of tissue insult when nerve impairment, failure to progress in a strengthening program intended to avoid surgery and clarification of anatomy prior to surgery. In this case, the worker's working diagnoses are chronic strain; chronic lumbar sprain; bilateral hand first CMC joint arthritis; bilateral carpal tunnel syndrome; and status post carpal release right wrist. The injured worker presented to a new provider on April 9, 2015 (an orthopedist). The injured worker had multiple complaints including neck, bilateral shoulders, upper extremities, low back and gastrointestinal symptoms. According to a November 2014 progress note, the injured worker received physical therapy; however, the location and total number of physical therapy sessions were not documented in the record. Subjectively, the injured worker has ongoing neck pain. Objectively, the worker had tenderness palpation in the paraspinal muscle groups with decreased range of motion (mild). There are no neurologic deficits referable to the upper extremities. There is no

clinical documentation demonstrating radiculopathy. There were no red flags in the medical record. There is no conservative treatment directed at the cervical spine. There are no unequivocal objective findings that identify specific nerve compromise on the neurologic evaluation. Consequently, absent clinical documentation with red flags, conservative treatment directed at the cervical spine and unequivocal objective findings that identify specific nerve compromise, MRI cervical spine is not radically necessary.

MRI of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-5. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back section, MRI lumbar spine.

Decision rationale: Pursuant to the Official Disability Guidelines, MRI of the lumbar spine is not medically necessary. MRIs of the test of choice in patients with prior back surgery, but for uncomplicated low back pain, with radiculopathy, it is not recommended until after at least one month conservative therapy, sooner if severe or progressive neurologic deficit. Repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and findings suggestive of significant pathology. Indications (enumerated in the official disability guidelines) for imaging include, but are not limited to, lumbar spine trauma, neurologic deficit; uncomplicated low back pain with red flag; uncomplicated low back pain prior lumbar surgery; etc. ACOEM states unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients not respond to treatment and who would consider surgery an option. See the ODG for details. In this case, the worker's working diagnoses are chronic strain; chronic lumbar sprain; bilateral hand first CMC joint arthritis; bilateral carpal tunnel syndrome; and status post carpal release right wrist. The injured worker presented to a new provider on April 9, 2015 (an orthopedist). The injured worker had multiple complaints including neck, bilateral shoulders, upper extremities, low back and gastrointestinal symptoms. According to a November 2014 progress note, the injured worker received physical therapy; however, the location and total number of physical therapy sessions were not documented in the record. Subjectively, the injured worker has ongoing neck pain. Objectively, the worker had tenderness palpation in the paraspinal muscle groups with decreased range of motion (mild). There are no neurologic deficits referable to the lower extremities. There is no clinical documentation demonstrating radiculopathy. There were no red flags in the medical record. There is no conservative treatment directed at the lumbar spine. There are no unequivocal objective findings that identify specific nerve compromise on the neurologic evaluation. Consequently, absent clinical documentation with red flags, conservative treatment directed at the lumbar spine and unequivocal objective findings that identify specific nerve compromise, MRI lumbar spine is not radically necessary.

EMG (electromyography)/NCV (nerve conduction velocity) of the bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Criteria for Nerve conduction studies (NCS).

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 section, EMG/NCV.

Decision rationale: Pursuant to the Official Disability Guidelines, bilateral lower extremity EMG/NCV is not medically necessary. Nerve conduction studies are not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. EMGs may be useful to obtain unequivocal evidence of radiculopathy, after one-month conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious. The ACOEM states unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging if symptoms persist. In this case, the worker's working diagnoses are chronic strain; chronic lumbar sprain; bilateral hand first CMC joint arthritis; bilateral carpal tunnel syndrome; and status post carpal release right wrist. The injured worker presented to a new provider on April 9, 2015 (an orthopedist). The injured worker had multiple complaints including neck, bilateral shoulders, upper extremities, low back and gastrointestinal symptoms. According to a November 2014 progress note, the injured worker received physical therapy, however the location and total number of physical therapy sessions were not documented in the record. Subjectively, the injured worker has ongoing neck pain. Objectively, the worker had tenderness palpation in the paraspinal muscle groups with decreased range of motion (mild). There are no neurologic deficits referable to the lower extremities. There is no clinical documentation demonstrating radiculopathy. There are no unequivocal objective findings that identify specific nerve compromise on the neurologic evaluation. Consequently, absent clinical documentation with lower extremity radicular symptoms and neurologic findings that identify specific or non-specific nerve compromise, bilateral lower extremity EMG/NCV is not medically necessary.