

Case Number:	CM15-0109720		
Date Assigned:	06/16/2015	Date of Injury:	02/04/2013
Decision Date:	07/23/2015	UR Denial Date:	05/15/2015
Priority:	Standard	Application Received:	06/08/2015

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: Pennsylvania

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 62 year old woman sustained an industrial injury on 2/4/2013. The injury occurred when her foot got caught in a floor mat and she tripped and stumbled to prevent a fall. Diagnoses include carpal tunnel syndrome, lumbago, and cervicgia. Treatment has included oral medications, physical therapy, and neck surgery. MRI of the lumbar spine on 2/10/14 showed multilevel degenerative changes with mild multilevel neural foraminal stenosis. A Qualified Medical Examination on 2/17/15 notes examination findings including focal tenderness of the neck with decreased range of motion, negative Spurling test, Tenderness of the bilateral acromioclavicular joint, no instability of the shoulders with negative provocative testing and positive impingement, right wrist with dorsal tenderness, mildly positive Tinel's and Phalen's tests and no focal atrophy, left wrist with mild tenderness at the basal joint, mildly positive Tinel's sign and no focal atrophy, normal neurovascular examination of the upper extremities, tenderness and spasm of the lumbar spine with decreased range of motion, left ankle with tenderness about the anterolateral gutter but otherwise normal examination of the left ankle, and normal lower extremity neurovascular examination. Physician notes on a PR-2 dated 3/31/2015 show complaints of constant cervical spine pain with radiation to the bilateral upper extremities and associated headaches rated 7/10, constant low back pain with radiation to the bilateral lower extremities rated 8/10, bilateral wrist/hand pain rated 7/10, and bilateral shoulder pain rated 7/10. At a visit on 5/5/15, the injured worker reported unchanged pain in the cervical spine, low back, bilateral wrists and hands, and bilateral shoulders. It was noted that right shoulder injection helped temporarily. Examination of the wrist/hand showed tenderness of the volar aspect of the

wrist, positive Tinel's and Phalens maneuvers, and no clinical evidence of instability (side not specified). Examination of the cervical spine showed paravertebral tenderness, positive Spurling's maneuver, numbness into the lateral forearm and hand, greatest over the thumb and middle finger which correlates with a C6 and C7 dermatomal pattern, and strength rated 4 in the wrist extensors and flexors as well as biceps, triceps, and fingers extensors (side not specified). Examination of the shoulder showed tenderness around the anterior glenohumeral region and subacromial space, Hawkins and impingement signs positive, with intact but painful rotator cuff function, and no evidence of instability (side not specified). Exam of the lumbar spine showed paravertebral muscle tenderness and spasm, positive seated nerve root test, numbness in the lateral thigh, anterolateral and posterior leg and foot, L5 and S1 dermatomal pattern, and strength rated 4 in the extensor hallucis longus and ankle plantar flexors, L5 and S1 innervated muscles (side not specified). Examination of the ankle was not documented. The examination findings were unchanged from prior reports from the treating physician dating back to December 2014. On 5/15/15, Utilization Review non-certified requests for the items currently under Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI Lumbar Spine: 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).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305, 309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back chapter: MRI.

Decision rationale: The ACOEM guidelines state that unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient to warrant imaging in patients who do not respond to treatment and who would consider surgery as an option. When the neurologic examination is less clear, further physiologic evidence of nerve dysfunction, such as electromyography, should be obtained before ordering an imaging study. Imaging studies should be reserved for cases in which surgery is considered or red-flag diagnoses are being evaluated. Magnetic resonance imaging (MRI) is the test of choice for patients with prior back surgery. Computed tomography or MRI is recommended when cauda equina, tumor, infection, or fracture are strongly suspected and plain film radiographs are negative. The ODG states that repeat MRI is indicated when there is significant change in symptoms and/or findings suggestive of significant pathology such as tumor, infection, fracture, neurocompression, or recurrent disc herniation. In this case, the physician documented numbness and decreases strength in the lower extremity but did not specify whether this was in the right or left leg or both lower extremities. Examination findings were discrepant from the findings documented by the Qualified Medical Examination. It was noted that the injured worker had an MRI in 2014 with findings as described; there was no documentation of re-injury or change in symptoms since that MRI. No electrodiagnostic testing was submitted. There was no documentation of red-flag conditions or plan for surgery. There were no unequivocal objective

findings that identify specific nerve compromise on the neurologic examination documented, as the laterality of the findings was not specified. Due to unequivocal objective findings on examination, lack of red flag conditions, and lack of documentation of re-injury or worsening clinical condition since the prior MRI of the lumbar spine, the request for MRI of the lumbar spine is not medically necessary.

MRI (B) Wrists/Hands: 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).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-269. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) forearm, wrist, and hand chapter: MRI.

Decision rationale: The ACOEM states that for most patients with hand and wrist problems, special studies are not needed until after a four to six week period of conservative care and observation. MRI is relatively more able to identify infection. The ODG states that MRI may be useful in selected cases when there is a high clinical suspicion of a fracture despite normal radiographs. Additional indications for MRI include acute hand or wrist trauma with suspicion of thumb metacarpophalangeal ulnar collateral ligament injury, chronic wrist pain with normal radiographs and suspicion of soft tissue tumor, and chronic wrist pain with plain films normal or equivocal and suspicion of Kienbock's disease. In this case, there was no documentation of plain radiographs of the wrists and hands. There was no documentation of high clinical suspicion of fracture or infection. There was no documentation of response to conservative care. Due to lack of documentation of prior plain radiographs, the request for MRI of the bilateral wrists and hands is not medically necessary.

MRI (L) Ankle: 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).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 374. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ankle and foot chapter: MRI.

Decision rationale: The ACOEM foot and ankle chapter states that magnetic resonance imaging (MRI) may be helpful in cases of delayed healing. The ODG states that MRI is indicated for chronic ankle pain of uncertain etiology with plain films normal. There were no plain radiographs of the ankle submitted or discussed. The ODG lists specific indications for MRI imaging of the ankle; none of these indications was documented to be present for this injured worker. The most recent progress note from the treating physician did not include examination of the ankle, and there were minimal findings documented on examination of the ankle at the Qualified Medical Examination in February 2015. Due to lack of specific indication, the request for MRI of the left ankle is not medically necessary.

MRI (B) Shoulders: 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).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 200, 207-209. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder chapter: MRI.

Decision rationale: The ACOEM states that for most patients with shoulder problems, special studies are not needed unless a four to six week period of conservative care and observation fails to improve symptoms. For patients with limitations of activity after four weeks and unexplained physical findings, such as effusion or localized pain, imaging may be indicated to clarify the diagnosis and assist reconditioning. Primary criteria for ordering imaging studies are emergence of a red flag, physiologic evidence of tissue insult or neurovascular dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of anatomy prior to an invasive procedure. None of these criteria was documented to be present for this injured worker. MRI is relatively better able to identify or define pathology such as rotor cuff tear, recurrent dislocation, tumor, and infection. There was no documentation of clinical suspicion of any of these conditions. Minimal abnormal findings on examination of the shoulders were noted, and the most recent examination by the treating physician did not discuss separate examination of the right and left shoulder. Rotator cuff function was noted to be intact, and the documentation notes no instability. Due to lack of specific indication/criteria, the request for MRI of bilateral shoulders is not medically necessary.

EMG BUE: 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).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 8 Neck and Upper Back Complaints Page(s): ch 8 p. 168-171, 182, ch 11 p. 260-262, 268-269, 272. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck and upper back chapter: EMG, nerve conduction studies, carpal tunnel syndrome chapter: electrodiagnostic studies.

Decision rationale: The ACOEM recommends EMG (electromyogram) to clarify nerve root dysfunction in cases of suspected disk herniation preoperatively or before epidural steroid injection. The ODG notes that EMG is moderately sensitive in relation to cervical radiculopathy. While cervical electrodiagnostic studies are not necessary to demonstrate a cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality, diabetic neuropathy, or some problem other than a cervical radiculopathy, with caution that these studies can result in unnecessary over treatment. The ACOEM states that in cases of peripheral nerve impingement, if no improvement or worsening has occurred within four to six weeks, electrical studies may be indicated. The ACOEM states that appropriate electrodiagnostic studies may help

differentiate between carpal tunnel syndrome and other conditions such as cervical radiculopathy. These may include nerve conduction studies and electromyography. The ODG states the recommended electrodiagnostic testing for carpal tunnel syndrome includes nerve conduction studies, and states that the addition of electromyography is not generally necessary. Electrodiagnostic studies are recommended in patients with clinical signs of carpal tunnel syndrome who may be candidates for surgery. In this case, there were some findings such as Tinel's and Phalen's sign that are suggestive of carpal tunnel syndrome, but no specific symptoms consistent with carpal tunnel syndrome were discussed. There was no discussion of plan for surgery for carpal tunnel syndrome. There were some dermatomal findings noted on examination, but the side of these findings was not specified. Due to insufficiently specific examination for findings related to the cervical spine, and lack of indication for EMG for diagnosis of carpal tunnel syndrome, the request for EMG of the bilateral upper extremities is not medically necessary.

EMG BLE: 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).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304, 309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back chapter: EMGs (electromyography), nerve conduction studies.

Decision rationale: The ACOEM states that electromyography (EMG) may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. The ODG states that EMG may be useful to obtain unequivocal evidence of radiculopathy after one month of conservative therapy, but that EMGs are not necessary if radiculopathy is already clinically obvious. There are no reports from the prescribing physician, which adequately describe neurologic findings that necessitate electrodiagnostic testing. Some dermatomal findings were noted at the most recent visit but the laterality of these findings was not specified, and the findings were discrepant from those of the Qualified Medical Examination. Medical necessity for electrodiagnostic testing is established by a clinical presentation with a sufficient degree of neurologic signs and symptoms to warrant such tests. The MTUS, per the citations listed above, outlines specific indications for electrodiagnostic testing, and these indications are based on specific clinical findings. The physician should provide a diagnosis that is likely based on clinical findings, and reasons why the test is needed. Due to insufficiently specific neurological findings on examination, the request for EMG of the bilateral lower extremities is not medically necessary.