

Case Number:	CM15-0132997		
Date Assigned:	07/21/2015	Date of Injury:	11/23/2014
Decision Date:	09/25/2015	UR Denial Date:	06/15/2015
Priority:	Standard	Application Received:	07/09/2015

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, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 62 year old female who sustained an industrial injury on November 23, 2014. She has reported left shoulder pain and has been diagnosed with left shoulder pain and shoulder tendinitis. Treatment has included medications, physical therapy, medical imaging, ice, injection, and rest. She has made good gains on her range of motion, but is still very easily fatiguable and unable to lift heavy. She had lifted her 19 pound granddaughter a few days prior and her left shoulder hurt for days. She was unable to abduct her arm for more than a few seconds, but she would seldom use this movement overall at work. MRI dated February 17, 2015 revealed 12 mm partial thickness articular surface supraspinatus tendon tear with possible small full thickness component and background severe tendinosis, severe sup fiber subscapularis and infraspinatus tendinosis with small focal partial thickness tear of infraspinatus tendon, mild long head of biceps tendinosis and tenosynovitis, and mild subacromial subdeltoid bursitis. The treatment request included Cold therapy pads, cold therapy unit, EMG of the left and right upper extremity, and NCV of the right and left upper extremity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cold therapy unit: 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), Shoulder: Continuous-flow cryotherapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Continuous-flow cryotherapy.

Decision rationale: The MTUS is silent on the use of cold therapy units. The ODG states continuous-flow cryotherapy is "Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (e.g., muscle strains and contusions) has not been fully evaluated. The available scientific literature is insufficient to document that the use of continuous-flow cooling systems (versus ice packs) is associated with a benefit beyond convenience and patient compliance (but these may be worthwhile benefits) in the outpatient setting." As the ODG only supports the use of cold therapy units for up to 7 days, purchase is not medically necessary. It should be noted that the UR physician has certified a modification of the request for 7 day rental.

Cold therapy pads: 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), Shoulder: Continuous-flow cryotherapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Durable Medical Equipment (DME).

Decision rationale: The Official Disability Guidelines state that durable medical equipment (DME) is defined as a device that can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, and is appropriate for use in a patient's home. DME includes bathroom and toilet supplies, assistive devices, TENS unit, home exercise kits, cryotherapy, orthoses, cold/heat packs, etc. As the requested cold therapy unit was not medically necessary, the request is not medically necessary. It should be noted that the UR physician has certified a modification of the request for 7 supply.

Electromyogram (EMG) of the right upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Elbow: Tests for cubital tunnel syndrome (ulnar nerve entrapment).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

Decision rationale: ACOEM guidelines support ordering of imaging studies for emergence of red flags, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a 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. Per MTUS ACOEM p182, with regard to the detection of neurologic abnormalities, EMG for diagnosis of nerve root involvement if findings of history, physical exam, and imaging study are consistent, is not recommended. The documentation submitted for review does not contain evidence of neurologic dysfunction such as sensory, reflex, or motor system deficit regarding the right upper extremity. The injured worker is not presented as having radiculopathy. There are no changes presented that suggest the presence of a peripheral neuropathy. The request is not medically necessary.

Electromyogram (EMG) of the left upper extremity: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Elbow: Tests for cubital tunnel syndrome (ulnar nerve entrapment).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

Decision rationale: ACOEM guidelines support ordering of imaging studies for emergence of red flags, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a 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. Per MTUS ACOEM page 182, with regard to the detection of neurologic abnormalities, EMG for diagnosis of nerve root involvement if findings of history, physical exam, and imaging study are consistent, is not recommended. MRI of the left shoulder dated 2/17/15 revealed 12mm antero-posterior partial thickness articular surface supraspinatus tendon tear with a possible small full thickness component on a background of severe tendinosis. Up to severe superior fiber subscapularis and

infraspinatus tendinosis also seen with a small focal partial thickness tear of the infraspinatus tendon. Mild long head of the biceps tendinosis and tenosynovitis. Mild subacromial-subdeltoid bursitis. X-ray of the left shoulder dated 3/16/15 documented a type II acromion, no bony or soft tissue abnormalities. Per the documentation submitted for review, it is noted that the injured worker had pain radiation in the left upper arm, and numbness to the hand which had been present for 1 month per 5/14/15 progress report. She had numbness on the left hand ulnar digits per this exam. I respectfully disagree with the UR physician's denial based upon the assertion that conservative care was not failed. The injured worker was participating in physical therapy yet symptoms persisted. The request is medically necessary.

Nerve conduction velocity (NCV) of the right upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Elbow: Tests for cubital tunnel syndrome (ulnar nerve entrapment).

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, Nerve conduction studies (NCS).

Decision rationale: Per the ODG guidelines with regard to NCS: Not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. (Utah, 2006) This systematic review and meta-analysis demonstrate that neurological testing procedures have limited overall diagnostic accuracy in detecting disc herniation with suspected radiculopathy. (Al Nezari, 2013) In the management of spine trauma with radicular symptoms, EMG/nerve conduction studies (NCS) often have low combined sensitivity and specificity in confirming root injury, and there is limited evidence to support the use of often uncomfortable and costly EMG/NCS. (Charles, 2013) See also the Carpal Tunnel Syndrome Chapter for more details on NCS. Studies have not shown portable nerve conduction devices to be effective. EMGs (electromyography) are recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. As the requested treatment is not recommended, the request is not medically necessary.

Nerve conduction velocity (NCV) of the left upper extremity: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Elbow: Tests for cubital tunnel syndrome (ulnar nerve entrapment).

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, Nerve conduction studies (NCS).

Decision rationale: Per the ODG guidelines with regard to NCS: Not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. (Utah, 2006) This systematic review and meta-analysis demonstrate that neurological testing procedures have limited overall diagnostic accuracy in detecting disc herniation with suspected radiculopathy. (Al Nezari, 2013) In the management of spine trauma with radicular symptoms, EMG/nerve conduction studies (NCS) often have low combined sensitivity and specificity in confirming root injury, and there is limited evidence to support the use of often uncomfortable and costly EMG/NCS. (Charles, 2013) See also the Carpal Tunnel Syndrome Chapter for more details on NCS. Studies have not shown portable nerve conduction devices to be effective. EMGs (electromyography) are recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. MRI of the left shoulder dated 2/17/15 revealed 12mm antero-posterior partial thickness articular surface supraspinatus tendon tear with a possible small full thickness component on a background of severe tendinosis. Up to severe superior fiber subscapularis and infraspinatus tendinosis also seen with a small focal partial thickness tear of the infraspinatus tendon. Mild long head of the biceps tendinosis and tenosynovitis. Mild subacromial-subdeltoid bursitis. X-ray of the left shoulder dated 3/16/15 documented a type II acromion, no bony or soft tissue abnormalities. Per the documentation submitted for review, it is noted that the injured worker had pain radiation in the left upper arm, and numbness to the hand which had been present for 1 month per 5/14/15 progress report. She had numbness on the left hand ulnar digits per this exam. I respectfully disagree with the UR physician's denial based upon the assertion that conservative care was not failed. The request is medically necessary.