MAXIMUS Federal Services

| Case Number: | CM15-0136286 | | |
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| Date Assigned: | 07/27/2015 | Date of Injury: | 05/05/2012 |
| Decision Date: | 08/26/2015 | UR Denial Date: | 06/25/2015 |
| Priority: | Standard | Application Received: | 07/14/2015 |

## 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: Texas, New York, California
Certification(s)/Specialty: Preventive Medicine, Occupational 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 applicant is a represented 39-year-old who has filed a claim for chronic neck, elbow, arm, and shoulder pain reportedly associated with an industrial injury of May 5, 2012. In a Utilization Review report dated June 25, 2015, the claims administrator failed to approve requests for cervical MRI imaging and electrodiagnostic testing of the bilateral upper extremities. The claims administrator referenced a June 12, 2015 progress note in its determination. The applicant's attorney subsequently appealed. On June 12, 2015, the applicant reported ongoing complaints of neck, shoulder, elbow, arm, and knee pain. The note was very difficult to follow as it mingled historical issues with current issues. The applicant reported radiation of neck pain to left arm and left hand. The applicant had had earlier electrodiagnostic of July 7, 2012 notable for a left- sided C6 radiculopathy with possible involvement of the C4 and/or C7 nerve roots as well. The applicant had subacute, acute, and chronic radicular components evident on said electro-diagnostic testing of July 7, 2012, it was reported. The applicant was given various diagnoses, including cervical kyphosis, cervical spinal stenosis, cervical spondylolysis, and cervical radiculopathy. The applicant had also developed issues with depression, headaches, and somatization disorder, it was reported. MRI imaging of the cervical spine and electrodiagnostic testing of the bilateral upper extremities were sought. It was stated that the applicant could have considered either shoulder surgery or cervical spine surgery. It was not stated how the proposed diagnostic test would influence or alter the treatment plan, however. The attending provider also ordered a left shoulder surgery consultation and electrodiagnostic testing of the bilateral upper

extremities, it was acknowledged. The attending provider acknowledged that the applicant had received earlier cervical epidural steroid injections at various points over the course of the claim.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI cervical:** 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): 182.

**Decision rationale:** No, the request for cervical MRI imaging was not medically necessary, medically appropriate, or indicated here. While the MTUS Guideline in ACOEM Chapter 8, Table 8-8, page 182 does recommend MRI or CT imaging of the cervical spine to validate a diagnosis of nerve root compromise, based on clear history and physical exam findings, in preparation for an invasive procedure, here, however, there was neither an explicit statement (nor an implicit expectation) that the applicant would act on the results of the proposed cervical MRI and/or go on to consider surgical intervention based on the outcome of the same. The attending provider reported on June 12, 2015 that the applicant already had an established diagnosis of cervical radiculopathy. The applicant had apparently had earlier positive cervical MRI imaging and electrodiagnostic testing, the treating provider acknowledged, in August 2012. It did not appear that the applicant was actively considering or contemplating cervical spine surgery based on the outcome of the cervical MRI in question. The History of Present Illness section of the attending provider's June 12, 2015 progress note explicitly stated that the applicant had apparently consulted a spine surgeon in the past who stated that the applicant was "not a candidate for cervical spine surgery" based on earlier suboptimal results from cervical epidural steroid injection therapy. Here, the attending provider did not explicitly state that the applicant was actively considering cervical spine surgery as of the date in question, June 12, 2015. Given the multiplicity and multifocal nature of the applicant's pain complaints and superimposed mental health issues, it was/is difficult to infer or extrapolate that the applicant would in fact act on the results of the MRI in question and/or go on to consider surgical intervention based on the outcome of the same. Therefore, the request was not medically necessary.

**Electromyography (EMG)/Nerve conduction velocity (NCV) bilateral upper extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 182; 272.

**Decision rationale:** Similarly, the request for electrodiagnostic testing of the bilateral upper extremities was likewise not medically necessary, medically appropriate, or indicated here. As noted in the MTUS Guideline in ACOEM Chapter 8, Table 8-8, page 182, EMG testing is "not recommended" for diagnosis of nerve root involvement if findings of history, physical examination, and/or imaging study are consistent. Here, the applicant already carried a diagnosis of clinically-evident, radiographically-confirmed, electrodiagnostic-confirmed cervical radiculopathy, per electrodiagnostic testing and MRI imaging of 2012. The prior positive test result, thus, effectively obviated the need for the electrodiagnostic testing in question. It was not clearly stated or clearly established how or why repeat electrodiagnostic was indicated. It was not stated how the repeat electrodiagnostic testing would influence or alter the treatment plan, given the fact that the diagnosis of cervical radiculopathy had already been definitively established. The applicant's radicular pain complaints, moreover, were seemingly confined to the symptomatic left upper extremity. The MTUS Guideline in ACOEM Chapter 11, Table 11-7, page 272 notes that the routine usage of electrodiagnostic testing in the evaluation of applicants without symptoms is deemed "not recommended." The request for electrodiagnostic testing of the bilateral upper extremities to include testing of the seemingly asymptomatic right upper extremity, thus, was at odds with ACOEM principles and parameters. Therefore, the request was not medically necessary.