

Case Number:	CM15-0161303		
Date Assigned:	08/27/2015	Date of Injury:	09/24/2014
Decision Date:	10/08/2015	UR Denial Date:	08/06/2015
Priority:	Standard	Application Received:	08/17/2015

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

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 56 year old male who sustained an industrial injury on 09-24-2014 to his right shoulder. The injured worker was diagnosed with right rotator cuff and impingement syndrome. No surgical interventions were documented. Treatment to date has included diagnostic testing, chiropractic therapy, right subacromial injection, physical therapy, oral steroids, steroid injections, chiropractic therapy and medications. According to the primary treating physician's progress report on July 16, 2015, the injured worker was evaluated for the right cervical spine area, trapezius and right shoulder. Several documents within the submitted medical records were difficult to decipher. Examination demonstrated loss of motion of the cervical spine and right shoulder on active range of motion. Passive range of motion of the right shoulder was full. Current medications were listed as Ultram and Restoril. Treatment plan consists of the current request for neurology consultation, Electromyography (EMG) and Nerve Conduction Velocity (NCV) of the bilateral upper extremities and cervical spine magnetic resonance imaging (MRI).

IMR ISSUES, DECISIONS AND RATIONALES

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

Neurology Consult: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM 2nd edition 2004 page 127.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) ACOEM guidelines, chapter 7, Independent Medical Examinations (IMEs), page 127.

Decision rationale: The 56 year old patient presents with right rotator cuff syndrome and right impingement syndrome, as per progress report dated 07/16/15. The request is for neurology consult. There is no RFA for this case, and the patient's date of injury is 09/24/14. Diagnoses, as per progress report dated 04/27/15, included shoulder impingement syndrome and lateral epicondylitis. Medications, as per progress report dated 04/14/15, included Hydrocodone, Naproxen and Omeprazole. The patient is on modified duty, as per progress report dated 07/16/15. American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) ACOEM guidelines, chapter 7, Independent Medical Examinations (IMEs), page 127 state that the occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A referral may be for consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. MTUS Guidelines pages 98 to 99 state that for patients with "myalgia and myositis, 9 to 10 sessions over 8 weeks are allowed, and for neuralgia, neuritis, and radiculitis, 8 to 10 visits over 4 weeks are allowed." In this case, several progress reports are handwritten and difficult to decipher. The request for neurology evaluation is noted in progress reports dated 04/10/15 and 07/16/15. The treater does not explain the purpose of the request. As per progress report dated 04/14/15, the patient suffers from neck pain, rated at 10/10, that radiates to right shoulder blade, right arm, and upper back. The treater, however, does not document any neurological deficits that may warrant an evaluation from a neurologist. Given the lack of relevant documentation, the request is not medically necessary.

EMG bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines -Neck and Upper Back chapter.

MAXIMUS guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Special Studies.

Decision rationale: The 56 year old patient presents with right rotator cuff syndrome and right impingement syndrome, as per progress report dated 07/16/15. The request is for EMG bilateral upper extremities. There is no RFA for this case, and the patient's date of injury is 09/24/14. Diagnoses, as per progress report dated 04/27/15, included shoulder impingement syndrome and lateral epicondylitis. Medications, as per progress report dated 04/14/15, included Hydrocodone, Naproxen and Omeprazole. The patient is on modified duty, as per progress report dated

07/16/15. For EMG, ACOEM Guidelines, chapter 11, Forearm, Wrist, and Hand Complaints chapter and Special Studies section, page 303 states "Electromyography, including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks." ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11, page 260-262 states: "Appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful. NCS and EMG may confirm the diagnosis of CTS but may be normal in early or mild cases of CTS. If the EDS are negative, tests may be repeated later in the course of treatment if symptoms persist." In this case, several progress reports are handwritten and difficult to decipher. None of the progress reports discuss this request. As per progress report dated 04/14/15, the patient suffers from neck pain, rated at 10/10, that radiates to right shoulder blade, right arm, and upper back. The patient also suffers from right elbow pain that is attributed to the arm pain and right arm pain that radiates to the right shoulder blade. An EMG may help evaluate the right upper extremity symptoms and lead to accurate diagnosis. However, the progress reports do not document any pain, discomfort or neurologic deficits in the left upper extremity. Hence, the request for EMG of bilateral upper extremities is not medically necessary.

NCV bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, and Forearm, Wrist, and Hand Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines -Neck and Upper Back chapter.

MAXIMUS guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Special Studies.

Decision rationale: The 56 year old patient presents with right rotator cuff syndrome and right impingement syndrome, as per progress report dated 07/16/15. The request is for NCV bilateral upper extremities. There is no RFA for this case, and the patient's date of injury is 09/24/14. Diagnoses, as per progress report dated 04/27/15, included shoulder impingement syndrome and lateral epicondylitis. Medications, as per progress report dated 04/14/15, included Hydrocodone, Naproxen and Omeprazole. The patient is on modified duty, as per progress report dated 07/16/15. For NCV, ACOEM Guidelines, chapter 11, Forearm, Wrist, and Hand Complaints chapter and Special Studies section, page 303 states "Electromyography, including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks." ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11, page 260-262 states: "Appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful. NCS and EMG may confirm the diagnosis of CTS but may be normal in early or mild cases of CTS. If the EDS are negative, tests may be repeated later in the course of treatment if symptoms persist." In this case, several progress reports are handwritten and difficult to decipher. None of the progress reports discuss this request. As per progress report dated 04/14/15, the patient suffers from neck pain, rated at 10/10, that radiates to right shoulder blade, right arm, and upper back. The patient also suffers from right elbow pain that is attributed to the

arm pain and right arm pain that radiates to the right shoulder blade. A NCV may help evaluate the right upper extremity symptoms and lead to accurate diagnosis. However, the progress reports do not document any pain, discomfort or neurologic deficits in the left upper extremity. Hence, the request for NCV of bilateral upper extremities is not medically necessary.

MRI of cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (acute and chronic) Chapter, under Magnetic Resonance Imaging.

Decision rationale: The 56 year old patient presents with right rotator cuff syndrome and right impingement syndrome, as per progress report dated 07/16/15. The request is for MRI of cervical spine. There is no RFA for this case, and the patient's date of injury is 09/24/14. Diagnoses, as per progress report dated 04/27/15, included shoulder impingement syndrome and lateral epicondylitis. Medications, as per progress report dated 04/14/15, included Hydrocodone, Naproxen and Omeprazole. The patient is on modified duty, as per progress report dated 07/16/15. ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8, Neck and Upper Back chapter and Special studies section, pages 177-178 under "Special Studies and Diagnostic and Treatment Considerations" states: "Neck and upper back complaints, under special studies and diagnostic and treatment considerations: Physiologic evidence of tissue insult or neurologic dysfunction. It defines physiologic evidence as a form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans." ACOEM further states that "unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient imaging to warrant imaging studies if symptoms persist." ODG Guidelines, Neck and Upper Back (acute and chronic) Chapter, under Magnetic Resonance Imaging states: Not recommended except for indications listed below. Indications for imaging MRI: Chronic neck pain (equals after 3 months of conservative treatment), radiographs are normal, neurologic signs or symptoms present. Neck pain with radiculopathy of severe or progressive neurologic deficit. In this case, several progress reports are handwritten and difficult to decipher. As per progress report dated 04/14/15, the patient suffers from neck pain, rated at 10/10, that radiates to right shoulder blade, right arm, and upper back. In progress report dated 04/10/15, the treater states that the patient needs an MRI because there is a CS component. However, none of the progress reports available for review document neurological findings that may warrant an MRI. The patient does not present with any red flags such as myelopathy or bowel/bladder symptoms either. ODG Guidelines do not support MRI unless there are neurologic signs/symptoms. Therefore, the requested MRI of the cervical spine is not medically necessary.