

Case Number:	CM15-0168487		
Date Assigned:	09/09/2015	Date of Injury:	09/17/2010
Decision Date:	10/13/2015	UR Denial Date:	07/29/2015
Priority:	Standard	Application Received:	08/26/2015

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:

This is a 56 year old female with a date of injury on 9-17-2010. A review of the medical records indicates that the injured worker is undergoing treatment for ulnar neuropathy on the left, status post neurolysis of the left ulnar nerve at the elbow (x2), right lateral epicondyle pain, probable lateral epicondylitis, bilateral stenosing tenosynovitis of the thumbs, adhesive capsulitis of the left shoulder with partial tear of the supraspinatus tendon and status post bilateral carpal tunnel release with residual carpal tunnel syndrome. Medical records (5-4-2015 to 7-6-2015) indicate ongoing neck pain radiating down the bilateral upper extremities. The pain was accompanied by numbness and tingling in the left upper extremity. She complained of low back pain radiating down the bilateral lower extremities. She also complained of pain in the left shoulder, elbow, hand and thumb. Records also indicate (6-18-2015) that the injured worker "really cannot use her hands and she has difficulty with all activities of daily living at home". The physical exam (6-9-2015 to 6-18-2015) reveals pain and sensitivity around the left elbow with tenderness and ulnar nerve irritation. She had bilateral thumb triggering. She was wearing her thumb spica braces. She continued with stiffness and spasm of the neck. There was spasm and tenderness over the lumbar spine with decreased range of motion. Treatment has included surgery, injections and pain medications (Oxycontin, Oxycodone and Neurontin). The original Utilization Review (UR) (7-29-2015) non-certified requests for magnetic resonance imaging (MRI) of the cervical spine and electromyography (EMG) - nerve conduction velocity (NCV) of the bilateral upper extremities.

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 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) k and Upper Back chapter, under Magnetic resonance imaging (MRI).

Decision rationale: Based on the 5/22/15 progress report provided by the treating physician, this patient presents with constant neck pain with headaches radiating to the bilateral upper extremities with numbness/tingling to the fingers, and constant low back pain radiating to the bilateral lower extremities with intermittent numbness/tingling, with overall pain rated 6-7/10 with medications and 9-10/10 without medications. The treater has asked for MRI Of The Cervical Spine but the requesting progress report is not included in the provided documentation. The request for authorization was not included in provided reports. The patient also reports constant pain/numbness/tingling and pins and needles sensation in the left palm, top of the hand, and the little/ring fingers radiating to the elbow per 6/26/15 report. The patient also states that she has bilateral thumb locking per 6/26/15 report. The patient is s/p x-rays of the cervical spine which show a "very small osteophyte at C5-6, but the lower vertebrae (C7-8) are not clearly seen and no evidence of Lushka osteophytes noted on these films" per 6/26/15 report. The patient's work status is temporarily totally disabled per 6/30/15 report. MTUS/ACOEM Guidelines, Neck and Upper back Complaints Chapter under Special Studies Section, chapter 8, page 177 and 178, state "Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option." ODG Guidelines, Neck and Upper Back chapter, under Magnetic resonance imaging (MRI) has the following criteria for cervical MRI: (1) Chronic neck pain (after 3 months conservative treatment), radiographs normal, neurologic signs or symptoms present; (2) Neck pain with radiculopathy if severe or progressive neurologic deficit; (3) Chronic neck pain, radiographs show spondylosis, neurologic signs or symptoms present; (4) Chronic neck pain, radiographs show old trauma, neurologic signs or symptoms present; (5) Chronic neck pain, radiographs show bone or disc margin destruction; (6) Suspected cervical spine trauma, neck pain, clinical findings suggest ligamentous injury (sprain), radiographs and/or CT "normal"; (7) Known cervical spine trauma: equivocal or positive plain films with neurological deficit; (8) Upper back/thoracic spine trauma with neurological deficit. The treater does not discuss this request in the reports provided. AME dated 5/29/15 shows prior MRIs of the C-spine from 4/11/03, 12/21/07, and 2/13/10. The most recent cervical MRI from 2/13/10 showed "C3-4 1-2mm right > left ridging/uncovertebral osteophytes with moderate/severe right and mild left facet arthropathy contribute to mild/moderate right foraminal stenosis and mild left foraminal stneosis. C5-6 2-3mm left paracentrally protruded disc with mild facet arthropathy contributes to mild/moderate spinal canal stenosis with left ventral cord indentation and mild cord flattening. The above, in addition to 1-2mm bilateral uncovertebral contributes to mild bilateral foraminal stenosis" per 5/29/15 AME report. In this case, the patient's most recent MRI was taken 5 years ago. However, the

patient has not had a re-injury, nor is there documentation of progressive neurological deficit or a planned surgical intervention. There is no documentation of spondylosis, old trauma, bone or disc margin destruction, suspected spine trauma or ligamentous injury. The treater does not provide a rationale for an updated MRI, either. The request is not medically necessary.

Electromyography/Nerve Conduction Velocity bilateral upper extremity: Overturned

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 EMG.

Decision rationale: Based on the 5/22/15 progress report provided by the treating physician, this patient presents with constant neck pain with headaches radiating to the bilateral upper extremities with numbness/tingling to the fingers, and constant low back pain radiating to the bilateral lower extremities with intermittent numbness/tingling, with overall pain rated 6-7/10 with medications and 9-10/10 without medications. The treater has asked for Electromyography/Nerve Conduction Velocity Bilateral Upper Extremity but the requesting progress report is not included in the provided documentation. The request for authorization was not included in provided reports. The patient also reports constant pain/numbness/tingling and pins and needles sensation in the left palm, top of the hand, and the little/ring fingers radiating to the elbow per 6/26/15 report. The patient also states that she has bilateral thumb locking per 6/26/15 report. The patient is s/p x-rays of the cervical spine which show a "very small osteophyte at C5-6, but the lower vertebrae (C7-8) are not clearly seen and no evidence of Lushka osteophytes noted on these films" per 6/26/15 report. The patient's work status is temporarily totally disabled per 6/30/15 report. MTUS/ACOEM guidelines, Chapter 8 Page 178 under neck chapter states, "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. The assessment may include sensory-evoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected." ODG Guidelines, Neck and upper back (acute and chronic) Chapter under EMG states "recommended as an option in select cases. ODG further states regarding EDS in carpal tunnel syndrome, recommended in patients with clinical signs of CTS and may be candidates for surgery. Electrodiagnostic testing includes testing for nerve conduction velocities (NCV), with the additional electromyography (EMG) is not generally necessary." The treater does not discuss this request in the reports provided. Per 5/29/15 AME report, the patient had a prior EMG/NCV of upper extremities on 2/21/15 that showed "severe left ulnar neuropathy at the elbow-moderate right ulnar neuropathy at the elbow affecting moderate conduction velocity slowing across the

elbow without evidence of significant motor conduction block. There is no evidence of active motor denervation. Mild bilateral median sensory conduction delays across the carpal tunnels in this setting most likely is attributable to residual conduction changes in this patient with a history of bilateral carpal tunnel release surgeries. The median motor nerve conduction findings are within normal limits. There is no evidence of motor conduction block of motor denervation, bilaterally. There is no electrodiagnostic evidence of radial neuropathies at the forearms or elbows, bilateral or cervical radiculopathy, C5-T1 nerve roots, bilaterally." However, there is no documentation of progressive neurological deficit. The patient is not s/p a re-injury, has not had any surgeries to the neck or upper extremities since the 2/21/15 EMG/NCV of bilateral upper extremities per review of reports. However, the AME report dated 5/29/15 recommends a bilateral trigger thumb release. It appears the treater is requesting EMG/NCV of bilateral upper extremities to evaluate prior to the planned surgical intervention. The requested updated electrodiagnostic studies are reasonable and the request is medically necessary.