

Case Number:	CM15-0186609		
Date Assigned:	09/28/2015	Date of Injury:	09/23/2014
Decision Date:	11/24/2015	UR Denial Date:	09/16/2015
Priority:	Standard	Application Received:	09/22/2015

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: Emergency 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 injured worker is a 50 year old female, who sustained an industrial injury on 9-23-14. The injured worker is being treated for right shoulder strain, right hand-finger strain and right elbow strain. Treatment to date has included acupuncture treatment, oral anti-inflammatories, therapy and cortisone injections. On 9-1-15, the injured worker complains of "intermittent pain". Work status is noted to be modified duties. Physical exam performed on 9-1-15 revealed low back pain rated 8-9 out of 10, right shoulder pain and right DeQuervain's carpal tunnel syndrome. On 9-1-15 a request for authorization was submitted for bilateral upper extremity (EMG) Electromyogram, (MRI) magnetic resonance imaging of cervical spine, lumbar spine and right hand-wrist and an ergonomic work station evaluation and adjustment. On 9-16-15 a request for bilateral upper extremity (EMG) Electromyogram, (MRI) magnetic resonance imaging of cervical spine, lumbar spine and right hand-wrist and an ergonomic work station evaluation and adjustment was non-certified by utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG (Electromyography) of bilateral upper extremities: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and upper back/EMGs (electromyography).

Decision rationale: The request is for an EMG. The ODG state the following regarding this topic: Recommended (needle, not surface) as an option in selected cases. The American Association of Electrodiagnostic Medicine conducted a review on electrodiagnosis in relation to cervical radiculopathy and concluded that the test was moderately sensitive (50%-71%) and highly specific (65%-85%). (AAEM, 1999) EMG findings may not be predictive of surgical outcome in cervical surgery, and patients may still benefit from surgery even in the absence of EMG findings of nerve root impingement. This is in stark contrast to the lumbar spine where EMG findings have been shown to be highly correlative with symptoms. Indications when particularly helpful: EMG may be helpful for patients with double crush phenomenon, in particular, when there is evidence of possible metabolic pathology such as neuropathy secondary to diabetes or thyroid disease, or evidence of peripheral compression such as carpal tunnel syndrome. In this case, the patient does not meet criteria for the study requested. This is secondary to poor physical exam findings suggestive of peripheral nerve compression. Pending receipt of information further clarifying how this study would change the management rendered, the study is not medically necessary.

MRI (magnetic resonance imaging) of the cervical spine: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and upper back complaints/MRI.

Decision rationale: The request is for an MRI. The ACOEM guidelines state that when there is physiological evidence of tissue insult or neurological deficits, consider a discussion with a consultant regarding the next steps including MRI imaging. An imaging study may be appropriate in patients where symptoms have lasted greater than 4-6 weeks and surgery is being considered for a specific anatomic defect or to further evaluate the possibility of serious pathology, such as a tumor. Reliance on imaging studies alone to evaluate the source of neck or upper back symptoms carries a significant risk of diagnostic confusion (false-positive test results) because it's possible to identify a finding that was present before symptoms began and, therefore, has no temporal association with the symptoms. The ODG guidelines regarding qualifying factors for an MRI of the neck or upper back are as follows: Indications for imaging - MRI (magnetic resonance imaging): Chronic neck pain (= after 3 months conservative treatment), radiographs normal, neurologic signs or symptoms present; Neck pain with radiculopathy if severe or progressive neurologic deficit; Chronic neck pain, radiographs show spondylosis, neurologic signs or symptoms present; Chronic neck pain, radiographs show old

trauma, neurologic signs or symptoms present; Chronic neck pain, radiographs show bone or disc margin destruction- Suspected cervical spine trauma, neck pain, clinical findings suggest ligamentous injury (sprain), radiographs and/or CT "normal"; Known cervical spine trauma: equivocal or positive plain films with neurological deficit; Upper back/thoracic spine trauma with neurological deficit. In this case, there is inadequate documentation in a change in neurologic status seen on exam. The records do not indicate new "red flags" which would warrant further imaging evaluation. Pending further information regarding new neurologic deficits, the request is not medically necessary.

MRI (magnetic resonance imaging) of the lumbar spine: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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 - Lumbar & Thoracic (Acute & Chronic)/ MRIs (magnetic resonance imaging).

Decision rationale: The request is for an MRI of the lumbar spine. The ODG guidelines state the following regarding qualifying criteria: Indications for imaging - Magnetic resonance imaging: Thoracic spine trauma: with neurological deficit- Lumbar spine trauma: trauma, neurological deficit; Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit); Uncomplicated low back pain, suspicion of cancer, infection, other "red flags"; Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit. Uncomplicated low back pain, prior lumbar surgery; Uncomplicated low back pain, cauda equina syndrome- Myelopathy (neurological deficit related to the spinal cord), traumatic; Myelopathy, painful- Myelopathy, sudden onset- Myelopathy, stepwise progressive- Myelopathy, slowly progressive- Myelopathy, infectious disease patient- Myelopathy, oncology patient; Repeat MRI: When there is significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation) In this case, the patient would not qualify for an MRI based on the above set standards. This is secondary to a lack of a change in clinical status or described "red flags". There is a lack of documentation of progressive neurologic deficit. Pending further information revealing qualifying indications as listed above, the request is not medically necessary.

MRI (magnetic resonance imaging) of the right hand/wrist: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, & Hand (Acute & Chronic)/ MRI's (magnetic resonance imaging).

Decision rationale: The request is for an MRI of the wrist/hand. The Official Disability Guidelines state the following regarding this topic: Recommended as indicated below. While criteria for which patients may benefit from the addition of MRI have not been established, in selected cases where there is a high clinical suspicion of a fracture despite normal radiographs, MRI may prove useful. (ACR, 2001) (Schmitt, 2003) (Valeri, 1999) (Duer, 2007) Magnetic resonance imaging has been advocated for patients with chronic wrist pain because it enables clinicians to perform a global examination of the osseous and soft tissue structures. It may be diagnostic in patients with triangular fibrocartilage (TFC) and intraosseous ligament tears, occult fractures, avascular neurosis, and miscellaneous other abnormalities. Many articles dispute the value of imaging in the diagnosis of ligamentous tears, because arthroscopy may be more accurate and treatment can be performed along with the diagnosis. (Dalinka, 2000) (Tehranzadeh, 2006) For inflammatory arthritis, high-resolution in-office MRI with an average follow-up of 8 months detects changes in bony disease better than radiography, which is insensitive for detecting changes in bone erosions for this patient population in this time frame. (Chen, 2006) See also Radiography. Indications for imaging - Magnetic resonance imaging (MRI): Acute hand or wrist trauma, suspect acute distal radius fracture, radiographs normal, next procedure if immediate confirmation or exclusion of fracture is required; Acute hand or wrist trauma, suspect acute scaphoid fracture, radiographs normal, next procedure if immediate confirmation or exclusion of fracture is required; Acute hand or wrist trauma, suspect gamekeeper injury (thumb MCP ulnar collateral ligament injury); Chronic wrist pain, plain films normal, suspect soft tissue tumor; Chronic wrist pain, plain film normal or equivocal, suspect Kienbock's disease; Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. (Mays, 2008) In this case, the request is not indicated. This is secondary to poor documentation of qualifying diagnosis as listed in the guidelines. As such, the request is not medically necessary.

Ergonomic work station evaluation and adjustment: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, wrist, hand (acute&chronic)/Ergonomic interventions.

Decision rationale: The request is for an ergonomic workstation. The official disability guidelines state the following regarding this topic: Under study. Using a computer keyboard with the forearms unsupported has been proposed as a causal factor for arm/hand diagnoses. For the majority of users, forearm support may be preferable to the "floating" posture in computer workstation setup. (Cook, 2004) An inverse relationship was found between level of job routinization and hand lacerations, with progressively higher rates of hand lacerations occurring among workers assigned to less routine (more variable) work patterns. (Bell, 2003) Symptoms in the wrist-hand region were predicted by stress symptoms and twisting or bending. Physical exposures at work influence the development of musculoskeletal symptoms in the neck-shoulder and wrist-hand regions. However, the results also suggest that a psychosocial exposure (social support) and perceived stress symptoms influence musculoskeletal symptoms. (Feveile, 2002) In this case, the request is not indicated. As stated above, this topic is under study with evidence suggesting a psychosocial component. As such, the request is not medically necessary.