

<b>Case Number:</b>	CM15-0188244		
<b>Date Assigned:</b>	09/30/2015	<b>Date of Injury:</b>	05/12/2011
<b>Decision Date:</b>	12/09/2015	<b>UR Denial Date:</b>	09/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/24/2015

### 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: Tennessee, Florida, Ohio  
 Certification(s)/Specialty: Surgery, Surgical Critical Care

### 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 53 year old female, who sustained an industrial injury on 5-12-11. She is diagnosed with post right rotator cuff repair with residual pain and multilevel cervical spondylosis. Her work status is temporary total disability. A note dated 8-17-15 reveals the injured worker presented with complaints of intermittent, slight bilateral neck pain with twitching and tingling into the arms bilaterally (right greater than left). The pain is increased by prolonged flexion and-or repetitive neck rotation. She also reports intermittent slight to moderate right shoulder pain associated by clicking and catching noises. The pain is increased by lifting, pushing, pulling and at or above shoulder level activities. A physical examination dated 8-17-15 revealed slight limited range of motion in the cervical spine with pain noted on terminal rotation bilaterally. There is slight tenderness on palpation in the "posterior cervical paravertebral muscles and trapezius muscles" bilaterally. There is also slight muscle spasm over the bilateral occipital nerve. Her right shoulder revealed moderate local tenderness "anteriorly in the subacromial bursa and slight tenderness posteriorly over the rotator cuff". Abduction against resistance demonstrated slight weakness and produced moderate pain. Circumduction caused slight pain and crepitation, and there was slight to moderate Neer impingement sign. Right shoulder range of motion is decreased. The bilateral wrists revealed local tenderness over the carpal canal (right greater than left). Treatment to date has included bilateral carpal tunnel (2006), rotator cuff repair (2013), lumbar cortisone injection (with relief per note dated 8-17-15), medications and physical therapy. Diagnostic studies to date have included ultra sound an MRI. A request for authorization dated 7-14-15 for bilateral upper extremities MRI and EMG-NVC bilateral upper extremities is denied, per Utilization Review letter dated 9-3-15.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **MRI (magnetic resonance imaging), Right Upper Extremity (RUE): Upheld**

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

**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 and Hand, MRI's (magnetic resonance imaging).

**Decision rationale:** There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. 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. MTUS does not address this topic. ODG states that an MRI may be warranted if patients meet the following criteria: 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. This patient has already had an MRI for functional evaluation. Repeat MRI is not recommended. Likewise, the patient has not had an acute trauma or injury that would require a full arm MRI. Imaging studies should be focused on clinical symptoms and not ordered in a "shot gun" approach. Therefore, based on the submitted medical documentation, the request for MRI of the right upper extremity is not medically necessary.

### **MRI (magnetic resonance imaging), Left Upper Extremity (LUE): Upheld**

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

**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 and Hand, MRI's (magnetic resonance imaging).

**Decision rationale:** There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. 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. MTUS does not address this topic. ODG states that an MRI may be warranted if patients meet the following criteria: 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. This patient has already had an MRI for functional evaluation. Repeat MRI is not recommended. Likewise, the patient has not had an acute trauma or injury that would require a full arm MRI. Imaging studies should be focused on clinical symptoms and not ordered in a "shot gun" approach. Therefore, based on the submitted medical documentation, the request for MRI of the left upper extremity is not medically necessary.

**EMG (electromyography)/ NCV (nerve conduction velocity), Right Upper Extremities (RUE): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Chronic Pain, EMG/NCS.

**Decision rationale:** There is not sufficient clinical information provided to justify the medical necessity of EMG/NCV testing for this patient. The California MTUS guidelines and the ACOEM Guidelines do not address the topic of EMG testing. The Occupational Disability Guidelines (ODG) states that "EMG is not recommended if radiculopathy is already clinically obvious." Additionally, the American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) recommends EMG testing only for medical indicated conditions; not for screening. EMG is further recommended after conservative therapy measures have failed. Although the medical records support that this patient has had arm and shoulder pain, there is no evidence that the patient's symptoms have been unresponsive to conservative measures, including bracing. Injection therapy provided relief on prior evaluation 8-17-15. Since the provider is requested these studies to "exclude" neurological dysfunction, their use is in a screening capacity and therefore not indicated. Therefore, based on the submitted medical documentation, the request for right upper extremity EMG/NCV testing is not medically necessary.

**EMG (electromyography)/ NCV (nerve conduction velocity), Left Upper Extremities (LUE): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Chronic Pain, EMG/NCS.

**Decision rationale:** There is not sufficient clinical information provided to justify the medical necessity of EMG/NCV testing for this patient. The California MTUS guidelines and the ACOEM Guidelines do not address the topic of EMG testing. The Occupational Disability Guidelines (ODG) states that "EMG is not recommended if radiculopathy is already clinically obvious." Additionally, the American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) recommends EMG testing only for medical indicated conditions; not for screening. EMG is further recommended after conservative therapy measures have failed. Although the medical records support that this patient has had arm and shoulder pain, there is no evidence that the patient's symptoms have been unresponsive to conservative measures, including bracing. Injection therapy provided relief on prior evaluation 8-17-15. Since the provider is requested these studies to "exclude" neurological dysfunction, their use is in a screening capacity and therefore not indicated. Therefore, based on the submitted medical documentation, the request for left upper extremity EMG/NCV testing is not medically necessary.