

Case Number:	CM15-0197979		
Date Assigned:	10/13/2015	Date of Injury:	08/13/2014
Decision Date:	11/25/2015	UR Denial Date:	10/05/2015
Priority:	Standard	Application Received:	10/08/2015

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: Iowa, Illinois, California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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:

This is a 40 year old female who sustained a work-related injury on 8-13-14. Medical record documentation on 9-10-15 revealed the injured worker was being treated for neck pain with radiation of pain to the upper extremities, headache, bilateral shoulder pain, and mid and low back pain with radiation of pain to the bilateral lower extremities. Objective findings included tenderness to palpation with hypertonicity and spasm over the bilateral paraspinal musculature and upper trapezius muscles. She had trigger points in the bilateral upper trapezius muscles. Spurling's maneuver elicited increased localized neck pain without radiation of pain. Her cervical spine range of motion was flexion to 40 degrees, extension to 50 degrees, and bilateral rotation to 60 degrees and bilateral lateral flexion to 30 degrees. She had tenderness to palpation over the bilateral paraspinal musculature of the thoracic and lumbar spine. She had tenderness to palpation over the interscapular musculature and lumbosacral junction. Straight leg raise was negative bilaterally. Her thoracic spine range of motion was flexion to 50 degrees and bilateral rotation to 20 degrees. Her lumbar spine range of motion was flexion to 45 degrees, extension to 15 degrees and bilateral side bending to 15 degrees. She had tenderness to palpation over the periscapular musculature, the biceps tendons bilaterally and the subacromial region bilaterally. She had subacromial crepitus. Her right shoulder range of motion was flexion to 170 degrees, extension to 40 degrees, abduction to 160 degrees, and adduction to 40 degrees, and internal-external rotation to 70 degrees. Range of motion of the left shoulder is flexion to 170 degrees, extension to 45 degrees, abduction to 165 degrees adduction to 40 degrees and internal-external

rotation to 70 degrees. Diagnoses included cervical spine musculoligamentous sprain-strain, thoracolumbar musculoligamentous sprain-strain and bilateral shoulder tendinitis and impingement. A request for EMG-NCV of the bilateral upper extremities and the bilateral lower extremities and a diagnostic u/s of the bilateral shoulders was received on 10-2-15. On 10-5-15, the Utilization Review physician determined EMG-NCV of the bilateral upper extremities and the bilateral lower extremities and a diagnostic u/s of the bilateral shoulders was not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Diagnostic Ultrasound Bilateral Shoulders: Overturned

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Summary.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, and Ultrasound diagnostic.

Decision rationale: ODG states "recommended as indicated below. The results of a recent review suggest that clinical examination by specialists can rule out the presence of a rotator cuff tear, and that either MRI or ultrasound could equally be used for detection of full-thickness rotator cuff tears, although ultrasound may be better at picking up partial tears. Ultrasound also may be more cost-effective in a specialist hospital setting for identification of full-thickness tears. (Dinnes, 2003) Ultrasound is a highly accurate imaging study for evaluating the integrity of the rotator cuff in shoulders that have undergone an operation. Its accuracy for operatively treated shoulders appears to be comparable with that previously reported for shoulders that had not been operated on. (Prickett, 2003) The rotator cuff and its environment can be imaged in many ways. In the hands of a few skilled sonographers, shoulder ultrasound has achieved remarkable success and accuracy. However, in many cases, radiologists are not equipped with the skill or time to provide this imaging modality to orthopedists. (Newberg, 2000) (Blankstein, 2005) A recent study found that ultrasound correctly identified 103 of 104 complete rotator cuff tears (sensitivity: 0.99--specificity: 0.99--accuracy: 98.7%). Preoperative ultrasound examination of the shoulder permits a reliable diagnosis of complete rotator cuff tears and calcium deposits (calcific tendinitis). The method is less sensitive but sufficiently reliable for the diagnosis of partial rotator cuff tears and pathology of the long biceps tendon. Examiner experience plays an important role in these special cases. (Kayser, 2005) Ultrasonography and magnetic resonance imaging have comparable high accuracy for identifying biceps pathologies and rotator cuff tears, and clinical tests have modest accuracy in both disorders. The choice of which imaging test to perform should be based on the patient's clinical information, cost, and imaging experience of the radiology department. (Ardic, 2006) Ultrasound scan (USS) of the shoulder is an accurate and reliable method of detecting full thickness RCTs, and it can reduce the time from GP referral to definitive diagnosis and management. The diagnostic accuracy of USS compared well with MRI. Clinical assessment alone was unreliable in diagnosing full thickness RCTs. (Miller, 2008)". The treating physician is trying to rule out rotator cuff pathology. ODG guidelines support the use of ultrasound for the diagnosis of rotator cuff pathology. As such the request for Diagnostic Ultrasound Bilateral Shoulders is

medically necessary.

EMG/NCV of the Bilateral Upper and Lower Extremities: Overturned

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies, and Forearm, Wrist, and Hand Complaints 2004, Section(s): Diagnostic Criteria, and Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic), Nerve conduction studies.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies, and Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Electrodiagnostic testing (EMG/NCS).

Decision rationale: ACOEM 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." ODG states "Recommended needle EMG or NCS, depending on indications. Surface EMG is not recommended. Electromyography (EMG) and Nerve Conduction Studies (NCS) are generally accepted, well-established and widely used for localizing the source of the neurological symptoms and establishing the diagnosis of focal nerve entrapments, such as carpal tunnel syndrome or radiculopathy, which may contribute to or coexist with CRPS II (causalgia), when testing is performed by appropriately trained neurologists or physical medicine and rehabilitation physicians (improperly performed testing by other providers often gives inconclusive results). As CRPS II occurs after partial injury to a nerve, the diagnosis of the initial nerve injury can be made by electrodiagnostic studies". ODG further clarifies "NCS is not recommended, but EMG is recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious." ODG states in the Low Back Chapter and Neck Chapter, "NCS is not recommended, but EMG is recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. Appropriately trained Physical Medicine and Rehabilitation or Neurology physicians should perform Electrodiagnostic studies. See also Monofilament testing". The treating physician notes a concern for radiculopathy of unknown origin and would like to rule out disc pathology. As such the request for EMG/NCV of the Bilateral Upper and Lower Extremities is medically necessary.