Case Number:	CM15-0200347		
Date Assigned:	10/15/2015	**Date of Injury:**	10/30/2011
Decision Date:	12/02/2015	**UR Denial Date:**	09/21/2015
Priority:	Standard	**Application Received:**	10/13/2015

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 60 year old female with a date of injury on 10-30-2011. The injured worker is undergoing treatment for sprain of shoulder-arm, adhesive capsulitis of the shoulder, sprain of the neck, brachial neuritis and cervical disc displacement. Comorbidities include hypertension, and congestive heart failure. She sustained another injury to her low back and lower extremities from 07-01-2005 to 10-22-2010 while working for another employer. A physician progress note dated 09-09-2015 documents the injured worker has constant pain in her left shoulder, along with weakness and tingling. She rates her pain level at 9 out of 10 on Visual Analog Scale. The pain travels to the left side of her neck and arm, down to the left wrist. She also has complaints of anxiety, depression, and insomnia due to the pain and injury. She has frequent headaches. She has gained approximately 50-60 pounds of weight as a result of this injury. She has difficulty with all ADLs. Cervical range of motion is restricted. There is cervical spine tightness, spasm, and muscle guarding at trapezius, sternocleidomastoid and strap muscles on the right. There is a positive Spurling's test, bilaterally and positive foraminal compression test. There is decreased sensation in C6, C7, C8, T1 and T2. Left shoulder range of motion is restricted. There is subacromial grinding and clicking on the left, and tenderness of the rotator cuff, and infraspinatus on the left. There is positive impingement test on the left. Elbow and wrist range of motion are intact. Thoracic range of motion is restricted. Lumbar spine range of motion is restricted in flexion and extension. There is tightness and spasm in the lumbar paraspinal musculature bilaterally. She has tenderness at the sciatic notch and sciatic nerve areas bilaterally. There is decreased sensation in L4, L5, and S1 on the right. The treatment plan includes a bone

scan of the entire body for Reflex Sympathetic Dystrophy, a psychological evaluation is needed due to emotional symptoms, and an Electromyography and Nerve Conduction Velocity are needed to establish the presence of radiculitis-neuropathy. She is temporarily totally disabled. Treatment to date has included diagnostic studies, medications, cortisone injections to her left shoulder, and physical therapy (with no benefit). Current medications include Spironolactone, Bumetanide, Metoprolol, Amlodipine, Benazepril, Omeprazole, Tramadol and Nitroglycerin. On 09-09-2015, prescriptions were written for Norco, Ultram, Prilosec, Gabapentin and Flexeril. The Request for Authorization dated 09-09-2015 included physical therapy 2-3 times a week for 6 weeks, bone scan of the entire body, outpatient Electromyography/Nerve Conduction Velocity of the bilateral upper extremities and a Psychological Evaluation. On 09-21-2015 Utilization Review non-certified the request for bone scans, outpatient Electromyography/Nerve Conduction Velocity of the bilateral upper extremities and a Psychological Evaluation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient Electromyography/Nerve Conduction Velocity of the bilateral upper extremities: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine, Chapter 7, 503-524.

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

Decision rationale: The 60 year old patient complains of pain in the left shoulder, rated at 9/10, radiating to left side of neck, arm and left wrist, along with anxiety, depression and insomnia, as per progress report dated 09/09/15. The request is for Outpatient Electromyography/Nerve Conduction Velocity of the bilateral upper extremities. The RFA for this case is dated 09/09/15, and the patient's date of injury is 10/30/11. Diagnoses, as per progress report dated 09/09/15, included left shoulder sprain/strain, rotator cuff tear, adhesive capsulitis, tendinitis, cervical sprain/strain with radiculitis/radiculopathy, herniated cervical disc, anxiety, depression, insomnia, and symptoms of sympathetic dystrophy of left upper extremity. Medications included Tramadol, Omeprazole, Benazepril, Amlodipine, Metoprolol, Bumetanidine, Spironolactone and Nitroglycerine. The patient is temporarily totally disabled, as per the same report. 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,

a request for EMG/NCV of the bilateral upper extremities is noted in the progress report dated 09/09/15. There is no indication that the patient underwent these studies in the past. Physical examination of the cervical spine, as per progress report dated 09/09/15, revealed tenderness to palpation along with decreased sensation along the C6, C7, C8 and T1 nerve distributions. Spurling's test and foraminal compression tests are also positive bilaterally. The treater is, therefore, requesting for electrodiagnostic studies to "establish the presence of radiculitis/neuropathy." The guidelines also support EMG/NCV as they may confirm this diagnosis and help with future care. Hence, the request for EMG/NCV appears reasonable and is medically necessary.

Bone scan: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine, Chapter 7, 503-524.

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) Chapter, under Bone scan, Pain chapter under CRPS, diagnostic tests and Other Medical Treatment Guidelines www.nlm.nih.gov/medlineplus/ency/article/003833.htm.

Decision rationale: The 60 year old patient complains of pain in the left shoulder, rated at 9/10, radiating to left side of neck, arm and left wrist, along with anxiety, depression and insomnia, as per progress report dated 09/09/15. The request is for Bone scan. The RFA for this case is dated 09/09/15, and the patient's date of injury is 10/30/11. Diagnoses, as per progress report dated 09/09/15, included left shoulder sprain/strain, rotator cuff tear, adhesive capsulitis, tendinitis, cervical sprain/strain with radiculitis/radiculopathy, herniated cervical disc, anxiety, depression, insomnia, and symptoms of sympathetic dystrophy of left upper extremity. Medications included Tramadol, Omeprazole, Benazepril, Amlodipine, Metoprolol, Bumetanidine, Spironolactone and Nitroglycerine. The patient is temporarily totally disabled, as per the same report. ODG-TWC, Low Back Lumbar & Thoracic (Acute & Chronic) Chapter, under Bone scan states "Not recommended, except for bone infection, cancer, or arthritis. (deVlam, 2000) (Littenberg, 1995) (ACR, 2000) [Note: This is different from the 1994 AHCPR Low Back Guideline, which said "Recommend if no improvement after 1 month" for Bone scan. (Bigos, 1999)] Bone scans use intravenous administration of tracer medications to show radioactive uptake to detect metastases, infection, inflammatory arthropathies, significant fracture, or other significant bone trauma."Bonescan for fractures: US national library of medicine NIH (http://www.nlm.nih.gov/medlineplus/ency/article/003833.htm) states a bone scan can be used to "Evaluate metabolic disorders, such as osteomalacia, renal osteodystrophy, primary hyperparathyroidism, osteoporosis, complex regional pain syndrome, and Paget's disease." ODG Pain chapter under CRPS, diagnostic tests (Imaging studies) states "Triple-phase bone scans (three-phasebone scintigraphy or TPBS): Recommended for select patients in early stages to help in confirmation of the diagnosis. Routine use is not recommended. The three phases are referred to as blood flow (first phase injection), blood pool (second phase at approx 2 minutes post injection), and delayed (third phase at approx 3 hours). The diagnosis is suggested when the

blood flow and blood pool images show diffuse asymmetric uptake, or when the delayed image indicates increased asymmetric periarticular uptake. There is research to suggest that the delayed phase is the most sensitive for the diagnosis. (Pankaj, 2006) (Wppenhorst, 2010) "In this case, a request for bone scan is noted in the progress report dated 09/09/15. The treater states the patient "will need to undergo bone scan of whole body for reflex sympathetic dystrophy." While the reports do indicate that the patient presents with symptoms of sympathetic dystrophy of left upper extremity, treater has not provided rationale for requesting whole body bone scan. There is no discussion on suspected metastases, inflammatory arthropathies, significant fracture, or other significant bone trauma. Per ODG, bone scan is "not recommended, except for bone infection, cancer, or arthritis." The request is not in accordance with guidelines. Therefore, the request for whole body bone scan is not medically necessary.

Psychological Evaluation: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine, Chapter 7, 503-524.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Chapter 7, page 127.

Decision rationale: The 60 year old patient complains of pain in the left shoulder, rated at 9/10, radiating to left side of neck, arm and left wrist, along with anxiety, depression and insomnia, as per progress report dated 09/09/15. The request is for Psychological Evaluation. The RFA for this case is dated 09/09/15, and the patient's date of injury is 10/30/11. Diagnoses, as per progress report dated 09/09/15, included left shoulder sprain/strain, rotator cuff tear, adhesive capsulitis, tendinitis, cervical sprain/strain with radiculitis/radiculopathy, herniated cervical disc, anxiety, depression, insomnia, and symptoms of sympathetic dystrophy of left upper extremity. Medications included Tramadol, Omeprazole, Benazepril, Amlodipine, Metoprolol, Bumetanidine, Spironolactone and Nitroglycerine. The patient is temporarily totally disabled, as per the same report.MTUS/ACOEM, Independent Medical Examinations and Consultations, chapter 7, page 127 states 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." In this case, a request for psychological evaluation is noted in the progress report dated 09/09/15. The treater states the patient needs psychosocial evaluation "due to emotional symptoms and complaints from ongoing pain the result of work-related injuries." The report also indicates that the patient complains of anxiety, depression and sleep issues. A psychologist may help with further diagnoses and treatment of these symptoms. Hence, the request for a psychological evaluation appears reasonable and is medically necessary.