

Case Number:	CM15-0203349		
Date Assigned:	10/20/2015	Date of Injury:	06/07/2008
Decision Date:	12/29/2015	UR Denial Date:	09/29/2015
Priority:	Standard	Application Received:	10/15/2015

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 male, who sustained an industrial injury on 6-7-2008. A review of the medical records indicates that the injured worker is undergoing treatment for chronic lumbosacral radiculopathy, chronic low back pain, rule out ankle sprain-strain, lateral left epicondylitis, rule out cubital tunnel syndrome, and chronic nonmalignant pain of the left shoulder, rule out impingement and rotator cuff tear. On 9-2-2015, the injured worker reported chronic pain in the left shoulder, elbow, and lumbar spine with recently developed pain in the right ankle as a result of altered ambulation. The Primary Treating Physician's report dated 9-2-2015, noted the injured worker's pain level was 7 out of 10 on a numeric pain rating scale with medications and 9 out of 10 without medications with pain suboptimally controlled with Norco. The physical examination was noted to show the injured worker visible uncomfortable ambulating with an antalgic gait with speed and impingement tests positive. Spasm and tenderness was noted over the paravertebral muscles of the lumbar spine with decreased range of motion (ROM) on flexion and extension and dysesthesia noted in the L5 and S1 dermatomal distributions bilaterally. Prior treatments have included physical therapy, left wrist surgery, and left elbow and left shoulder injections. The treatment plan was noted to include increasing the injured worker's Norco to address nociceptive pain adequately, and requests for authorization for a low back brace and cane, iontophoresis for the left elbow, electrodiagnostic studies of the left upper extremity, and a MRI of the left shoulder. The request for authorization dated 9-22-2015, requested an electromyography (EMG) of the left upper extremity, nerve conduction velocity (NCV) of the right upper extremity, nerve conduction velocity (NCV) of the left upper extremity,

electromyography (EMG) of the right upper extremity, a MRI of the left shoulder, and a lower back brace. The Utilization Review (UR) dated 9-29-2015, denied the requests for an electromyography (EMG) of the left upper extremity, nerve conduction velocity (NCV) of the right upper extremity, nerve conduction velocity (NCV) of the left upper extremity, electromyography (EMG) of the right upper extremity, a MRI of the left shoulder, and a lower back brace.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG of the left upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Summary, and Elbow Complaints 2007, Section(s): Diagnostic Criteria.

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

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of EMG 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 "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. This patient has clinically obvious, mild sensory deficits on physical exam. Radiculitis is not diagnosed in the medical documentation for this patient's upper extremity pain. The exam is being performed as screening to assess the patient's chronic shoulder pain. EMGs for screening are not indicated. Therefore, based on the submitted medical documentation, the request for EMG testing is not medically necessary.

NCV of the right upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Summary, and Elbow Complaints 2007, Section(s): Diagnostic Criteria.

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

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of right upper extremity nerve conduction testing for this patient. The California MTUS guidelines and the ACOEM Guidelines do not address the topic of nerve conduction studies. In the upper extremity, ODG states that Nerve Conduction Studies are: "Recommended as an option after closed fractures of distal radius & ulna if necessary to assess nerve injury. Also

recommended for diagnosis and prognosis of traumatic nerve lesions or other nerve trauma." Per ODG, NCV is not indicated for the upper extremities based on this patient's known and established diagnosis. Furthermore, the patient has no documented signs of clinical fracture or traumatic nerve injury. There is no documentation that this patient has failed conservative measures with splinting or injection therapy. Therefore, based on the submitted medical documentation, the request for upper nerve conduction study is not medically necessary.

NCV of the left upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Summary, and Elbow Complaints 2007, Section(s): Diagnostic Criteria.

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

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of left upper nerve conduction testing for this patient. The California MTUS guidelines and the ACOEM Guidelines do not address the topic of nerve conduction studies. In the upper extremity, ODG states that Nerve Conduction Studies are: "Recommended as an option after closed fractures of distal radius & ulna if necessary to assess nerve injury. Also recommended for diagnosis and prognosis of traumatic nerve lesions or other nerve trauma." Per ODG, NCV is not indicated for the bilateral upper extremities based on this patient's known and established diagnosis. Furthermore, the patient has no documented signs of clinical fracture or traumatic nerve injury. There is no documentation that this patient has failed conservative measures with splinting or injection therapy. Therefore, based on the submitted medical documentation, the request for upper nerve conduction study is not medically necessary.

EMG of the right upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Summary, and Elbow Complaints 2007, Section(s): Diagnostic Criteria.

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

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of EMG 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 "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. This patient has clinically obvious, mild sensory deficits on physical exam of the left upper extremity. The right extremity is without defect. Radiculitis is not diagnosed in the medical documentation.

Screening on asymptomatic limbs are not indicated. Therefore, based on the submitted medical documentation, the request for EMG testing is not medically necessary.

MRI of the left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Diagnostic Criteria, Special Studies.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Special Studies.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of a shoulder MRI for this patient. The MTUS guidelines recommend the following criteria for ordering special imaging studies in shoulder complaints: "Primary criteria for ordering imaging studies are: Emergence of a red flag (e.g., indications of intra-abdominal or cardiac problems presenting as shoulder problems). Physiologic evidence of tissue insult or neurovascular dysfunction (e.g., cervical root problems presenting as shoulder pain, weakness from a massive rotator cuff tear, or the presence of edema, cyanosis or Raynaud's phenomenon), Failure to progress in a strengthening program intended to avoid surgery. Clarification of the anatomy prior to an invasive procedure (e.g., a full- thickness rotator cuff tear not responding to conservative treatment)." Regarding this patient's case, the patient does not have any red flag signs, including neurovascular impairment, torticollis or concerning local features such as a mass lesion with bony tenderness or swelling. Therefore, based on the submitted medical documentation, the request for a MRI of the left shoulder is not medically necessary.

Lower back brace: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods.

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), Lumbar supports.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. MTUS and ACOEM fail to address this topic. Per ODG, lumbar support braces are: "Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option)." This patient has not been documented to have a specific cause for his back pain, which justifies the use of a brace. The patient has lumbar radiculopathy has not been demonstrate to improve with brace therapy. Therefore, based on the submitted medical documentation, the request for lumbar brace is not medically necessary.