Case Number:	CM15-0029779		
Date Assigned:	02/23/2015	**Date of Injury:**	02/19/2014
Decision Date:	04/23/2015	**UR Denial Date:**	01/29/2015
Priority:	Standard	**Application Received:**	02/17/2015

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: Indiana
Certification(s)/Specialty: Preventive Medicine, Occupational 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 55 year old female sustained an industrial injury on 2/19/14, with subsequent ongoing neck and bilateral upper extremity pain. In a PR-2 dated 1/15/15, the injured worker complained of a flare up of pain 5/10 on the visual analog scale to the neck and bilateral shoulders, elbows and wrists with numbness and tingling. The handwritten note was nearly illegible. Physical exam was remarkable for tenderness to palpation to the cervical spine, bilateral shoulder and bilateral elbows with decreased range of motion and positive Spurling's to the cervical spine, positive impingement and cross arm to bilateral shoulders and positive Cozen and Tinel's to bilateral elbows. The injured worker had completed 2 of 6 acupuncture sessions. The physician noted that the injured worker had failed conservative treatment. Current diagnoses included cervical spine sprain/strain with right upper extremity radiculitis, bilateral arm sprain/strain, bilateral elbow epicondylitis and bilateral wrist tenosynovitis. The treatment plan included in magnetic resonance imaging cervical spine, magnetic resonance imaging bilateral shoulders and electromyography/nerve conduction velocity test bilateral upper extremities. On 1/28/15, Utilization Review noncertified a request for magnetic resonance imaging bilateral shoulders, magnetic resonance imaging cervical spine and electromyography/nerve conduction velocity test bilateral upper extremities noting lack of documentation of conservative treatment and citing ACOEM guidelines. As a result of the UR denial, an IMR was filed with the Division of Workers Comp.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI Bilateral Shoulders: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints Page(s): 208-209, 178. Decision based on Non-MTUS Citation Official Disability Guidelines-ODG http://www.odg-twc.com/odgtwc/shoulder.htm#magneticresonanceimaging indications for imaging (MRI).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

Decision rationale: ACOEM states "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 Reynaud'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)"ODG states "Indications for imaging Magnetic resonance imaging (MRI): Acute shoulder trauma, suspect rotator cuff tear/impingement; over age 40; normal plain radiographs, Subacute shoulder pain, suspect instability/labral tear, 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)The employee meets the ODG criteria of impingement syndrome and age over 40, so the request for bilateral MRI of the shoulders is medically necessary.

MRI Cervical Spine: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178. Decision based on Non-MTUS Citation Official Disability Guidelines; http://www.odg-twc.com/odgtwc/neck.htm Indications for imaging MRI (magnetic resonance imaging); Chronic neck pain.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Magnetic resonance imaging (MRI).

Decision rationale: ACOEM states "Criteria for ordering imaging studies are: Emergence of a red flag, Physiologic evidence of tissue insult or neurologic dysfunction, Failure to progress in a strengthening program intended to avoid surgery and Clarification of the anatomy prior to an invasive procedure." ODG states, "Not recommended except for indications list below. Patients who are alert, have never lost consciousness, are not under the influence of alcohol and/or drugs, have no distracting injuries, have no cervical tenderness, and have no neurologic findings, do not need imaging." 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. The treating physician has provided evidence of several red flags to meet the criteria above. As, such the request for MRI OF THE CERVICAL SPINE is medically necessary.

EMG/NCV Bilateral Upper Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007), Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines; Electrodiagnostic stuides (EDS); Electromygraphy (EMG). hhp://www.odg-twc.comodgtwc/Carpal_Tunnel.htm#Electrodiagnostics studies.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Carpal Tunnel Syndrome, 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." Radiculopathy is obvious, so the request for EMG/NCV of bilateral upper extremities is not medically necessary.