

<b>Case Number:</b>	CM14-0132669		
<b>Date Assigned:</b>	08/22/2014	<b>Date of Injury:</b>	12/15/2008
<b>Decision Date:</b>	09/24/2014	<b>UR Denial Date:</b>	07/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/19/2014

### 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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 claimant was injured due to cumulative trauma on 12/15/2008. MRIs of the bilateral shoulders and chest/ribs and EMGs and nerve conduction studies for the upper extremities are under review. He was evaluated on 01/06/14 and reported symptom is in his neck, back, right groin, left shoulder, left wrist, hand, and fingers. His wrists were examined. On 02/03/14, he saw [REDACTED]. He was status post left wrist surgery on 01/24/14. His diagnoses were left wrist strain, rule out left CTS and triangular fibrocartilage tear. He reported pain in his wrist that radiated up his bilateral extremities to his shoulders. His wrists were examined but his shoulders were not. He had a panel QME by [REDACTED] on 02/14/14. He was found to be permanent and stationary on 08/31/10. He was diagnosed with bilateral inguinal hernias and underwent repairs in 2010. He was seen for internal medicine problems including gastrointestinal symptoms. He saw [REDACTED] on 07/07/14 and reported pain in his neck, left wrist and low back and the pain in his neck travels to his arms. He had numbness in his neck and numbness in his legs and swelling in the right foot. He had tenderness about the cervical spine with myospasm and sensory deficits in the left upper extremity with restricted range of motion. He had tenderness of the left wrist and thoracic spine. He had low back tenderness and spasms and limited range of motion with decreased sensation in the right lower extremity. On July 8, 2014, he saw [REDACTED]. He reported pain in his neck, shoulders, and low back and the neck pain traveled into his arms right greater than left. The pain in his right arm traveled to his thumb and he had numbness and tingling in his hands. He had pain in his low back to his toes with numbness and tingling and he complained of deep-seated rib and chest pain. He had tenderness with myospasm about the neck and decreased sensation in the bilateral C6 and C7 nerve root distributions with limited range of motion. He had tenderness about the shoulders with impingement and mildly weak supraspinatus. Range of motion was mildly decreased. Lumbar spine had tenderness with

myospasm and decreased sensation in the right L1 and S1 distributions with limited range of motion. He saw [REDACTED] on 07/22/14. He complained of pain in his neck, shoulders, and low back and his neck pain traveled through his arms to his thumbs. He had numbness and tingling in his thumbs. He had pain in the low back traveling to his right leg to his toes with numbness and tingling and deep-seated rib and chest pain. He had tenderness and myospasm about the cervical spine with decreased sensation of bilateral C6 and C7 nerve root distributions and limited range of motion. His shoulders had tenderness and impingement signs. He had weakness of the supraspinatus and limited range of motion with pain. He had tenderness of the low back with myospasm and sensory deficits at right L5 and S1 nerve root distributions in limited range of motion. He had a CT scan of the cervical spine on 06/25/14 that showed a solid interbody fusion at each level. He still had axial neck pain with herniated nucleus pulposus radiculopathy and stenosis. Right C6-7 selective nerve root block was recommended which expired on 03/27/14. Chest and ribs was recommended due to his deep-seated left anterior and posterior rib and chest pain. EMG of the bilateral upper extremities was recommended due to radiculopathy post-surgery. MRIs of the bilateral shoulders were also recommended. He had a surgical scar consistent with left dorsal wrist arthroscopy. Thoracic spine had tenderness and lumbar spine was tender with decreased sensation throughout the right lower extremity. There was myospasm and limited range of motion. He was status post three-level cervical fusion in 2012 from C4-5 through C6-7. He also had MRI evidence of lumbar strain with radicular complaints and herniation's at L4-5. He was diagnosed with acute right C6 and C7 radiculopathy. He also had posttraumatic stress, anxiety, and insomnia. MRIs of the bilateral shoulders were requested to rule out internal derangement. On 12/27/13, the right C6-7 selective nerve root block was authorized that he never has the injection. Repeat request for reauthorization was recommended. A psychological consultation was also ordered for his emotional complaints. Sleep study was ordered. He has tried multiple medications. He had an allergic reaction and gastritis. NCV/EMG of the bilateral upper extremities was recommended due to radicular complaints both post-surgery. Patient was recommended twice a week for 4 weeks to improve his range of motion pain and to strengthen his shoulders. He was placed on restricted work.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Magnetic Resonance Imaging of bilateral shoulders:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

**Decision rationale:** The history and documentation do not objectively support the request for MRIs of the bilateral shoulders. The MTUS states "for most patients with shoulder problems, special studies are not needed unless a four- to six-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided red-flag conditions are ruled out. There are a few exceptions: Stress films of the AC joints (views of both shoulders, with and without patient holding 15-lb weights) may be indicated if the clinical

diagnosis is AC joint separation. Care should be taken when selecting this test because the disorder is usually clinically obvious, and the test is painful and expensive relative to its yield. If an initial or recurrent shoulder dislocation presents in the dislocated position, shoulder films before and after reduction are indicated. Persistent shoulder pain, associated with neurovascular compression symptoms (particularly with abduction and external rotation), may indicate the need for an AP cervical spine radiograph to identify a cervical rib. Routine testing (laboratory tests, plain-film radiographs of the shoulder) and more specialized imaging studies are not recommended during the first month to six weeks of activity limitation due to shoulder symptoms, except when a red flag noted on history or examination raises suspicion of a serious shoulder condition or referred pain. Cases of impingement syndrome are managed the same regardless of whether radiographs show calcium in the rotator cuff or degenerative changes are seen in or around the glenohumeral joint or AC joint."In this case, there is no evidence of a trial and failure of a reasonable course of conservative care, including an exercise program, local modalities, and the judicious use of medications targeting the shoulders specifically. The claimant was evaluated for wrist problems and it is not clear when his shoulder symptoms began or whether or not he has attended any rehab visits for his shoulders. Patient was recently recommended for his shoulders but the status of that request, including whether or not the claimant attended rehab for his shoulders, his response, and his current status, are unknown. There are no new or progressive focal deficits for which this type of imaging study appears to be indicated. Impingement can be diagnosed clinically and there is no documentation of weakness such that a significant internal derangement appears to be present that may require surgery prior to conservative care. There is no evidence that urgent or emergent surgery is under consideration. Magnetic Resonance Imaging of bilateral shoulders is not medically necessary and appropriate.

**Nerve Conduction Velocity of upper extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

**Decision rationale:** The history and documentation do not objectively support the request for nerve conduction velocity of the bilateral upper extremities. The MTUS states "recommend NCV for median (B) or ulnar (C) impingement at the wrist after failure of conservative treatment." In this, there is no evidence of completion or a trial of conservative care for the claimant's current symptoms. There is no evidence of peripheral nerve compression or dysfunction in the wrists and hands to support proceeding with these studies prior to a trial of conservative care. The claimant had arthroscopic surgery for his left wrist but his course of post-op treatment is unclear. His course of conservative treatment for the right wrist, if any, has not been included in the submitted records. Nerve Conduction Velocity of upper extremities is not medically necessary and appropriate.

**Electromyogram of upper extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**Decision rationale:** The history and documentation do not objectively support the request for EMG of the bilateral upper extremities. The MTUS states "for most patients presenting with true neck or upper back problems, special studies are not needed unless a three- or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out. 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. Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. The assessment may include sensory-evoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected." In this case, the claimant reports chronic symptoms but there is no evidence of completion or a trial of conservative care for the claimant's chronic symptoms. He is status post cervical fusion surgery and there is no mention in the file that he has been involved in an ongoing exercise program for his cervical spine post-top, as would be expected. There is no clear evidence of likely focal radiculopathy on physical examination of the neck and upper extremities that requires an EMG prior to a trial of conservative care. In fact, PT has been recommended for his shoulders so conservative care for his neck, shoulders, and upper extremities does not appear to have been completed or tried and failed. Also, there is no explanation for why the selective nerve root block that had been approved was not done. The claimant had arthroscopic surgery for his left wrist but his course of postop treatment is unclear. His course of conservative treatment for the right upper extremity and wrist, if any, has not been included in the submitted records. Electromyogram of upper extremities is not medically necessary and appropriate.

**Magnetic Resonance Imaging of chest/ribs:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Pulmonary - MRI.

**Decision rationale:** The history and documentation do not objectively support the request for an MRI of the chest and ribs for chronic deep seated pain with no specific reported injury and where

lower level conservative care has not been reported. The MTUS do not address MRIs of the chest and the ODG state MRI may be "recommended only as an alternative to CT for detecting pulmonary metastases, primarily because exposure to ionizing radiation would be avoided, an issue of particular concern with young patients undergoing multiple follow-up examinations. Nevertheless, it is generally accepted that MRI does not currently have a role in screening of patients for pulmonary metastases. Motion-related artifacts, a lower spatial resolution than CT, and an inability to detect calcification within lesions all represent limitations of MRI. A recent study comparing turbo-spin echo MRI with spiral CT as a gold standard demonstrated a lower sensitivity for MRI in detecting pulmonary metastases; for 340 metastases identified on CT, the overall sensitivity of MRI was 84%, but for nodules <5 mm in diameter, sensitivity was only 36%. (Mohammed, 2006). For patients with either a known or suspected lung cancer who are eligible for treatment, a magnetic resonance imaging (MRI) of the chest should not be performed for staging the mediastinum but should be performed in patients with non-small cell lung cancer (NSCLC) involving the superior sulcus for evaluation of the brachial plexus or for evaluation of vertebral body invasion." There is no history of possible lung cancer or metastases and no chest x-rays or rib x-rays have been submitted. Magnetic Resonance Imaging of chest/ribs is not medically necessary and appropriate.