

<b>Case Number:</b>	CM14-0160329		
<b>Date Assigned:</b>	10/03/2014	<b>Date of Injury:</b>	10/12/2013
<b>Decision Date:</b>	11/06/2014	<b>UR Denial Date:</b>	09/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/29/2014

### 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 Physical Medicine and Rehabilitation 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 injured worker is a 53-year-old female who reported an injury on 10/12/2013. Reportedly while at work, repetitive use of her hands while using fork to clean seafood she sustained injuries to her neck and left shoulder. Her treatment history included surgery, medications, MRI studies, physical therapy. She was evaluated on 08/22/2014 and it was documented the injured worker complains of low back aching, stiffness and soreness especially with movement. Had associated intermittent bilateral lower extremity numbness and tingling, left more than right. Physical examination of the lumbar spine revealed tenderness to palpation of a quadratus lumborum, sacroiliac joint and paravertebral muscles, positive straight leg raise test and positive Kemp's test. Lumbar motion was limited in all planes with pain. Neurological function was intact. Examination of the bilateral wrist revealed tenderness to palpation of the wrist flexors and extensors, positive Tinel's sign, positive Phalen's test, limited motion in all planes. Injured worker had failed to improve with physical therapy, activity modification, and home exercise program and cortisone injection for the 3rd trigger digit. Diagnoses included bilateral CTS, left shoulder ACJ, degenerative joint disease, bilateral wrist CTS, and left wrist volar ganglion cyst, cervical sprain/strain with bilateral upper extremity radiculopathy, lumbar strain/sprain with bilateral lower extremity radiculopathy, and bilateral carpal tunnel syndrome. The Request for Authorization dated 08/22/2014 was for MRI for the lumbar spine, EMG/NCV of the bilateral lower extremities, and Cold Therapy Unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI of the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation ODG-TWC Low Back Procedure Summary

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** The request for the Magnetic Resonance Images of the Lumbar Spine is not medically necessary. ACOEM guidelines recommend imaging studies when physiologic evidence identifies specific nerve compromise on the neurologic examination. The rationale for the request was to re-evaluate and rule out a lumbar disc syndrome. There was no report of re-injury noted. Furthermore, the injured worker's physical examination findings are consistent with no change his current diagnosis. There is a lack of objective findings identifying specific nerve compromise to warrant the use of imaging. The injured worker has already had a MRI of the lumbar. The provider failed to indicate significant changes or nerve compromise on examination. There is also no indication of red flag diagnoses or the intent to undergo surgery. The request for MRI of the lumbar spine is not medically necessary.

**EMG/NCV of the bilateral lower extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation ODG-TWC Low Back Procedure Summary

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, NCV.

**Decision rationale:** The request for EMG/NCV of the bilateral lower extremities is not medically necessary. California MTUS/ACOEM Guidelines state that an electromyography may be useful to identify subtle, focal neurologic dysfunction in injured workers with low back symptoms lasting more than 3 or 4 weeks. There was a lack of neurological deficits pertaining to the lumbar spine documented. The clinical note revealed low back pain with radiation to lower bilateral extremities. The Official Disability guidelines state that an NCV is not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. The injured worker had low back pain and intermittent bilateral lower extremity symptoms, but there was limited evidence of neurologic deficits in the lower extremities on the physical examination suggestive of lumbar radiculopathy versus peripheral nerve compression to support the need for EMG/NCV of the bilateral extremities. As such, the request for EMG/NCV of the bilateral lower extremities is not medically necessary.

**Cold therapy unit (rental or purchase):** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265. Decision based on Non-MTUS Citation ODG-TWC Forearm, Wrist, and Hand

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulders (Acute and Chronic) Cold Therapy

**Decision rationale:** The requested is not medically necessary. The Official Disability Guidelines (ODG) does not recommend cold therapy for the shoulders. The guidelines states that deep venous thrombosis and pulmonary embolism events are common complications following lower-extremity orthopedic surgery, but they are rare following upper-extremity surgery, especially shoulder arthroscopy. It is still recommended to perform a thorough preoperative workup to uncover possible risk factors for deep venous thrombosis/ pulmonary embolism despite the rare occurrence of developing a pulmonary embolism following shoulder surgery. Mechanical or chemical prophylaxis should be administered for patients with identified coagulopathic risk factors. Although variability exists in the reported incidence of VTE, surgeons should still be aware of the potential for this serious complication after shoulder arthroplasty. Additionally, the request failed to indicate # of days of rental for the cold therapy unit and date of services and location where cold therapy unit for the injured worker. As such, the request for is not medically necessary.