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| Case Number: | CM14-0083881 | | |
| Date Assigned: | 07/21/2014 | Date of Injury: | 07/07/2013 |
| Decision Date: | 10/02/2014 | UR Denial Date: | 05/13/2014 |
| Priority: | Standard | Application Received: | 06/05/2014 |

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 Illinois. 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 injuries from a fall while descending a stairway on 07/07/2013. On 03/11/2014, her diagnoses included cervicalgia, displacement of cervical intervertebral disc without myelopathy, cervical radiculopathy, right shoulder joint pain, right shoulder supraspinatus and infraspinatus tendinosis, right shoulder biceps tendon tear, and right shoulder glenoid labral tear. Her complaints included constant neck pain traveling to her right shoulder and right arm to the wrist, which she rated at 7/10, lower back pain traveling to her right leg posteriorly to the calf, which she rated at 7/10. She also complained of sleep difficulties and symptoms of anxiety and depression due to pain, loss of work and weight gain. She stated that her pain was aggravated by prolonged walking, repetitive bending, stooping, kneeling, squatting, twisting, lifting, carrying, pushing, pulling, and climbing. She shared that her pain was reduced with activity modification, acupuncture, a TENS unit, and her medications. Her medications included omeprazole 20 mg, cyclobenzaprine 7.5 mg, and naproxen of an unknown dose. Upon examination of her upper extremities, it was noted that her grip strength was normal. Her cervical spine examination revealed that her reflexes for her biceps, triceps, and brachioradialis muscles were all within normal limits. She had no loss of sensation, abnormal sensation, or pain in the anterolateral shoulders on both sides. There was no rationale or Request for Authorization included in this worker's chart.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG of the Right Upper Extremity: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): EMG (Electromyography)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 272.

Decision rationale: The request for EMG of the Right Upper Extremity is not medically necessary. The California ACOEM Guidelines state that routine use of EMG in diagnostic evaluation of nerve entrapment or screening in patients without corresponding symptoms is not recommended. The need for an EMG was not clearly demonstrated in the submitted documentation. Therefore, this request for EMG of the Right Upper Extremity is not medically necessary.

NCV of the Right Upper Extremity: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): NCV (Nerve Conduction Velocities)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 272.

Decision rationale: The request for NCV of the Right Upper Extremity is not medically necessary. The California ACOEM Guidelines state that nerve conduction velocity studies are not recommended for all acute, subacute and chronic hand, wrist, and forearm disorders. The clinical information submitted failed to meet the evidence based guidelines for nerve conduction velocity studies. Therefore, this request for NCV of the Right Upper Extremity is not medically necessary.

MRI of the Right Wrist and Hand: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-269.

Decision rationale: The request for MRI of the Right Wrist and Hand is not medically necessary. Per the California ACOEM Guidelines, for most patients presenting with true hand and wrist problems, special studies are not needed until after a 4 to 6 week period of conservative care and observation. Most patients improve quickly, provided red flag conditions are ruled out. There was no evidence of red flag conditions included in the submitted documentation. The need for an MRI was not clearly demonstrated in the submitted documentation. Therefore, the request for MRI of the Right Wrist and Hand is not medically necessary.

MRI of the Thoracic Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179,182.

Decision rationale: The request for MRI of the Thoracic Spine is not medically necessary. The California ACOEM Guidelines recommend MRIs for acute neck and upper back conditions when red flags for fracture or neurologic deficit associated with acute trauma, tumor, or infection are present. There is no evidence in the submitted documentation that the injured worker had any of the above diagnoses or conditions. Additionally, an MRI of the thoracic spine was performed on 03/24/2014, there was no rationale or justification for a repeat MRI. Therefore, this request for MRI of the Thoracic Spine is not medically necessary.

MRI of the Right Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-208.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

Decision rationale: The request for MRI of the Right Shoulder is not medically necessary. Per the California ACOEM Guidelines, for most patients with shoulder problems, special studies are not needed unless a 4 to 6 week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided red flag conditions are ruled out. There was no evidence of red flags in the submitted documentation. Additionally, a right shoulder MRI was performed on 01/03/2014. There was no rationale or justification for a repeat MRI. Therefore, the request for MRI of the Right Shoulder is not medically necessary.