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| Case Number: | CM15-0122213 | | |
| Date Assigned: | 07/10/2015 | Date of Injury: | 11/21/2005 |
| Decision Date: | 08/05/2015 | UR Denial Date: | 06/12/2015 |
| Priority: | Standard | Application Received: | 06/24/2015 |

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 (IW) is a 66-year-old female who sustained an industrial injury on 11/21/2005. Diagnoses include status post left shoulder arthroscopic decompression. Treatment to date has included medications, physical therapy, left shoulder surgery and home therapy. According to the progress notes dated 5/27/15, the IW reported improvement of the left shoulder post-operatively, but continued weakness of the left hand. On examination, it appeared some range in flexion had been lost of the interphalangeal joint of the left thumb and of the distal interphalangeal (DIP) joints of the index and long fingers. Range of motion of the left shoulder was 170 degrees of flexion and abduction. A request was made for EMG/NCV (electromyography/nerve conduction velocity) study of the left upper extremity and MRI of the cervical spine to determine the cause of the left hand weakness.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV Left upper extremity: 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): Neck & Upper Back, Special Studies and Diagnostic and Treatment Considerations, pages 177-178.

Decision rationale: Per MTUS Guidelines, without specific symptoms or neurological compromise consistent with peripheral neuropathy or entrapment syndrome, radiculopathy, foraminal or spinal stenosis, medical necessity for EMG and NCV has not been established. Submitted reports have not demonstrated any symptoms or clinical findings to suggest any entrapment syndrome or cervical radiculopathy only with digit range of motion without neurological deficits or specific consistent myotomal or dermatomal correlation to support for the electrodiagnostics. There was no documented failed conservative trial for this chronic injury of 2005 without new injury or progressive neurological deficits. The EMG/NCV Left upper extremity is not medically necessary and appropriate.

MRI of the cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): Chapter 8 Neck and Upper Back Disorders, Introductory Material, Special Studies and Diagnostic and Treatment Considerations, page(s) 171-171, 177-179.

Decision rationale: Per ACOEM Treatment Guidelines for the Neck and Upper Back Disorders, criteria for ordering imaging include Emergence of a red flag; Physiologic evidence of tissue insult or neurologic dysfunction; Failure to progress in a strengthening program intended to avoid surgery; Clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist; however, review of submitted medical reports, including reports from the provider, have not adequately demonstrated the indication for the MRI of the Cervical spine nor document any specific clinical findings to support this imaging study as the patient has unchanged neurological deficit in bilateral upper extremities. When the neurologic examination is less clear, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. The MRI of the cervical spine is not medically necessary and appropriate.