

Case Number:	CM15-0126395		
Date Assigned:	07/10/2015	Date of Injury:	02/21/2015
Decision Date:	08/10/2015	UR Denial Date:	06/17/2015
Priority:	Standard	Application Received:	06/30/2015

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: Emergency 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:

The injured worker is a 47-year-old male who sustained an industrial injury on February 21, 2015. He has reported right knee pain and injuries to the hands and has been diagnosed with multiple pain sites-lumbar spine, right and left shoulder, right and left hands and carpal tunnel surgery bilateral wrists. Treatment has included conservative measures. He had a right knee brace with no spasm or guarding of the thoracic spine internal rotation of the lumbar spine. There was no overt shoulder instability on testing. There was a positive scratch collapse test right carpal tunnel. Scratch collapse test left carpal tunnel. There was no tenderness to bilateral lower extremities, no pain, or crepitation. Right knee had pain. X-ray of the right hand, wrist, shoulder, left hand, wrist, and shoulder were within normal limits. Documentation provided is poor. There is no rationale provided for any of the requested tests. Pan-body X-rays done including X-ray of lumbar spine, bilateral hands, wrists, pelvis and shoulders dated 6/4/15 were normal. The treatment request included EMG/NCV of the right and left upper extremities, MRI of the lumbar spine, and right and left shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV Right and Left Upper Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 182 and 272.

Decision rationale: EMG and NCV requested by provider are 2 different tests, testing for different pathologies. If one test is not recommended, this requested will be considered not medically necessary as per MTUS independent medical review guidelines. As per ACOEM Guidelines, Nerve Conduction Velocity Studies is not recommended for repeat "routine" evaluation of patients for nerve entrapment. It is recommended in cases where there are signs of median or ulnar nerve entrapment. There is no change in physical exam. Patient has a diagnosis of carpal tunnel syndrome. It is unclear how testing will change treatment of the underlying diagnosis or what conservative care has been attempted. There is no rationale provided for requested test. NCV is not medically necessary As per ACOEM Guidelines, EMG is not recommended if prior testing, history and exam is consistent with nerve root dysfunction. EMG is recommended if pre procedure or surgery is being considered. Pt has not had any documented changes in neurological exam or complaints. There is no exam or signs consistent with radiculopathy. There is no rationale about why testing is requested condition. EMG is not medically necessary. EMG and NCV of bilateral upper extremities are not medically necessary.

MRI of the Left and Right Shoulders: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208.

Decision rationale: As per MTUS ACOEM Guidelines, imaging of shoulders should be considered when there are emergence of red flag (limb or life threatening) findings, evidence of loss of neurovascular function, failure to progress in strengthening program and pre-invasive procedure. Patient fails all criteria. There are no red flags or signs of loss of neurovascular function. There are no neurological deficits. There is no plan for surgery. There is no documented conservative measures attempted provided in documentation. MRI of bilateral shoulders is not medically necessary.

MRI of the Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304 and 309.

Decision rationale: As per ACOEM Guidelines, imaging studies should be ordered in event of "red flag" signs of symptoms, signs of new neurologic dysfunction, clarification of anatomy prior to invasive procedure or failure to progress in therapy program. Patient does not meet any of these criteria. There are no documented red flag findings in complaints or exam. There is noted new neurologic dysfunction. There is no documented provided concerning what conservative measures has been attempted. There is no justification documented for why MRI of lumbar spine was needed. MRI of lumbar spine is not medically necessary.