Case Number:	CM15-0173536		
Date Assigned:	09/15/2015	Date of Injury:	11/11/2005
Decision Date:	11/06/2015	UR Denial Date:	09/02/2015
Priority:	Standard	Application Received:	09/03/2015

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: Arizona, Michigan
Certification(s)/Specialty: Preventive Medicine, Occupational 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 50-year-old male who sustained an industrial injury November 11, 2005. Diagnoses August 12, 2015 include superior glenoid labrum lesion, articular cartilage disorder involving forearm, and lateral epicondylitis. Documented treatment includes medication, prior left cubital tunnel release, right elbow cortisone injection, heat and ice contrast therapy, and at least 5 physical therapy sessions with visit number 5 stating "patient is progressing well." The injured worker continues to report worsened pain in bilateral shoulders, elbows and wrists interfering with sleep. Pain is rated 9 out of 10. The initial orthopedic evaluation July 2, 2015 reveals that symptoms are worse on the right and notes right shoulder pain and weakness with range of motion loss of 20 degrees on abduction and external rotation. The orthopedic evaluation states "clinical evidence of possible rotator cuff tear of the right shoulder versus labral tear, possible lateral epicondylitis of the left elbow versus ulnar neuritis, triangular fibrocartilage tear of the right wrist, and possible carpal tunnel syndrome of the right wrist." The treating physician's plan of care includes MRI of the right shoulder, elbow and wrist; and, electromyogram and nerve conduction velocity study of the bilateral upper extremities. This was denied September 2, 2015. Work status has been temporary total disability.

IMR ISSUES, DECISIONS AND RATIONALES

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

Magnetic resonance imaging (MRI) of the right shoulder: Overturned

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Special Studies.

Decision rationale: Per the MTUS/ ACOEM "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. For patients with limitations of activity after four weeks and unexplained physical findings, such as effusion or localized pain (especially following exercise), imaging may be indicated to clarify the diagnosis and assist reconditioning. Imaging findings can be correlated with physical findings. Primary criteria for ordering imaging studies are: "Emergence of a red flag (e.g., indications of intra-abdominal or cardiac problems presenting as shoulder problems)," Physiologic evidence of tissue insult or neurovascular dysfunction (e.g., cervical root problems presenting as shoulder pain, weakness from a massive rotator cuff tear, or the presence of edema, cyanosis or Reynaud's phenomenon) "Failure to progress in a strengthening program intended to avoid surgery." Clarification of the anatomy prior to an invasive procedure (e.g., a full thickness rotator cuff tear not responding to conservative treatment). A review of the injured worker's medical records reveal progressively worsening right upper extremity and shoulder complaints despite conservative management, x-rays have not revealed any bony abnormalities and MRI of the right shoulder appears prudent at this time, therefore the request for MRI of the right shoulder is medically necessary.

Magnetic resonance imaging (MRI) of the right elbow: Overturned

Claims Administrator guideline: Decision based on MTUS Elbow Complaints 2007.

MAXIMUS guideline: Decision based on MTUS Elbow Complaints 2007, Section(s): Diagnostic Criteria.

Decision rationale: The MTUS / ACOEM states that "for most patients presenting with elbow problems, special studies are not needed unless a period of at least 4 weeks of conservative care and observation fails to improve their symptoms. Most patients improve quickly, provided red flag conditions are ruled out". A review of the injured workers medical records reveal progressively worsening right upper extremity and elbow complaints despite conservative management. X-rays have not revealed any bony abnormalities and MRI of the right elbow

appears prudent at this time, therefore the request for MRI of the right elbow is medically necessary.

Magnetic resonance imaging (MRI) of the right wrist: Overturned

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Diagnostic Criteria.

Decision rationale: The MTUS / ACOEM states that 'for most patients presenting with true hand and wrist problems, special studies are not needed until after a four- to six-week period of conservative care and observation. Most patients improve quickly, provided red flag conditions are ruled out. A review of the injured workers medical records reveals progressively worsening right upper extremity complaints despite conservative management. X-rays have not revealed any bony abnormalities and MRI of the right wrist appears prudent at this time, therefore the request for MRI of the right wrist is medically necessary.

Electromyogram (EMG)/Nerve conduction velocity (NCV) of the bilateral upper extremities: Overturned

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic)/ Electrodiagnostic studies, Nerve conduction studies.

Decision rationale: Per ACOEM in the MTUS, most patients presenting with true neck and upper back problems do not need special studies until a 3-4 week period of conservative care fails to improve symptoms, most patients improve quickly once 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 neurological examination is less clear, however further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. EMG and NCV may help identify subtle focal neurologic dysfunction in patients with neck and or arm symptoms lasting more than 3-4 weeks. Per the ODG, NCS are not recommended to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but recommended if the EMG is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other

diagnoses may be likely based on the clinical exam. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy. While cervical electrodiagnostic studies are not necessary to demonstrate a cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality, diabetic neuropathy, or some problem other than a cervical radiculopathy, with caution that these studies can result in unnecessary over treatment. A review of the injured workers medical records reveal progressively worsening upper extremity and shoulder complaints despite conservative management, clarification of the source and extent of his neurologic symptoms is appropriate, therefore the request for Electromyogram (EMG)/Nerve conduction velocity (NCV) of the bilateral upper extremities is medically necessary.