Case Number:	CM15-0093042		
Date Assigned:	05/19/2015	**Date of Injury:**	02/16/2014
Decision Date:	06/23/2015	**UR Denial Date:**	04/20/2015
Priority:	Standard	**Application Received:**	05/14/2015

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: New Jersey, Alabama, California
Certification(s)/Specialty: Neurology, Neuromuscular 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 30 year old male, who sustained an industrial injury on 02/16/2014. He reported feeling pain in his neck, shoulders, right arm, and chest while attempting to lift a patient. The injured worker is currently off work. The injured worker is currently diagnosed as having cervical radiculopathy, upper back strain with radiculopathy, right shoulder sprain, right shoulder tendinitis, chest wall strain, and chronic pain. Treatment and diagnostics to date has included cervical spine MRI which showed mild degenerative disc disease and foraminal stenosis, right shoulder MRI on 05/30/2014 showed no evidence of occult rotator cuff tear, physical therapy, wrist brace, injection to the shoulder, electromyography/nerve conduction velocity study on 09/11/2014, and medications. In a progress note dated 04/10/2015, the injured worker presented with complaints of right shoulder/arm pain. Objective findings include neck tenderness to palpation and abnormal cervical, thoracic, and right shoulder range of motion. The treating physician reported requesting authorization for right shoulder MRI, electromyography/ nerve conduction studies to bilateral upper extremities, and functional capacity evaluation.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI right shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: According to MTUS guidelines, MRI of the shoulder is indicated in case of tumor, infection, ligament instability and rotator cuff injury. There is no clinical evidence or documentation of one of the above diagnosis. In fact, the right shoulder MRI performed on May 30, 2014 showed no evidence of occult rotator cuff tear. Therefore MRI of the right shoulder is not medically necessary.

EMG/NCV BUE: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Special studies and diagnostic and treatment considerations Page(s): 178.

Decision rationale: According to MTUS guidelines (MTUS page 303 from ACOEM guidelines), "Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks." EMG has excellent ability to identify abnormalities related to disc protrusion (MTUS page 304 from ACOEM guidelines). According to MTUS guidelines, needle EMG study helps identify subtle neurological focal dysfunction in patients with neck and arm symptoms. "When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks (page 178)." EMG is indicated to clarify nerve dysfunction in case of suspected disc herniation (page 182). EMG is useful to identify physiological insult and anatomical defect in case of neck pain (page 179). The patient developed chronic neck pain without recent evidence of radicular pain and no recent clear justification for the need of an EMG. Therefore, the request for EMG/NCV BUE is not medically necessary.

Functional capacity evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs, early intervention, Assessing Red Flags and Indication for Immediate Referral Page(s): 32-33, 171.

Decision rationale: According to MTUS guidelines, the presence of red flags may indicate the need for specialty consultation. In addition, the requesting physician should provide a documentation supporting the medical necessity for a pain management evaluation with a specialist. The documentation should include the reasons, the specific goals and end point for using the expertise of a specialist. In the chronic pain programs, early intervention section of MTUS guidelines stated: "Recommendations for identification of patients that may benefit from early intervention via a multidisciplinary approach: (a) The patient's response to treatment falls outside of the established norms for their specific diagnosis without a physical explanation to explain symptom severity. (b) The patient exhibits excessive pain behavior and/or complaints compared to that expected from the diagnosis. (c) There is a previous medical history of delayed recovery. (d) The patient is not a candidate where surgery or other treatments would clearly be warranted. (e) Inadequate employer support. (f) Loss of employment for greater than 4 weeks. The most discernible indication of at risk status is lost time from work of 4 to 6 weeks. (Mayer 2003)" There is no documentation that the patient condition require functional capacity evaluation. There is no strong scientific evidence that functional capacity evaluation predicts the patient ability to perform his work. In addition, the provider should document that the patient reached his MMI. The requesting physician should provide a documentation supporting the medical necessity for this evaluation. The documentation should include the reasons, the specific goals and end point for Functional Capacity Evaluation. Therefore, the request for Functional Capacity Evaluation is not medically necessary.