

<b>Case Number:</b>	CM13-0007879		
<b>Date Assigned:</b>	03/24/2014	<b>Date of Injury:</b>	01/30/2013
<b>Decision Date:</b>	04/22/2014	<b>UR Denial Date:</b>	07/08/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/06/2013

### 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 California. 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:

This female sustained an injury on 1/30/13 while employed by [REDACTED]. Requests under consideration include EMG BILATERAL UPPER EXTREMITY, EMG BILATERAL LOWER EXTREMITY, and PHYSICAL THERAPY 3 X 6 RIGHT ARM/ SHOULDER. Report of 6/28/13 from the provider noted patient with right arm and low back pain, right lower This female sustained an injury on 1/30/13 while employed by [REDACTED]. Requests under consideration include EMG BILATERAL UPPER EXTREMITY, EMG BILATERAL LOWER EXTREMITY, and PHYSICAL THERAPY 3 X 6 RIGHT ARM/ SHOULDER. Report of 6/28/13 from the provider noted patient with right arm and low back pain, right lower

### IMR ISSUES, DECISIONS AND RATIONALES

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

**EMG BILATERAL UPPER EXTREMITY:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007).

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

**Decision rationale:** This female sustained an injury on 1/30/13 while employed by [REDACTED]. Requests under consideration include EMG BILATERAL UPPER

EXTREMITY, EMG BILATERAL LOWER EXTREMITY, and PHYSICAL THERAPY 3 X 6 RIGHT ARM/ SHOULDER. Report of 6/28/13 from the provider noted patient with right arm and low back pain, right lower extremity pain and hip pain. The provider is awaiting the MRI reports from Kaiser. Exam noted cervical spine has normal appearance; negative Spurling's test; negative tenderness over the musculature; negative spasms; motor exam of 5/5 to all upper extremities muscle groups with intact DTRs 2+; lumbar spine has antalgic gait; negative tenderness of par lumbar and par thoracic musculature; positive tenderness in the posterior superior iliac spine region; negative SI joints; negative muscle spasm; motor testing 5/5 to all muscle groups; walking on heels without difficulty; DTRs 2+; negative SLR; normal range of lumbar spine. Diagnoses included Cervical strain; radiculitis right upper extremity; right arm pain; low back pain; radiculitis right lower extremity; and degenerative joint disease right hip. Treatment included Nucynta, Prilosec; Anaprox; EMG nerve conduction studies; continue PT 3x6 and awaiting MRI results. Per MTUS Guidelines, without specific symptoms or neurological compromise consistent with radiculopathy, foraminal or spinal stenosis, medical necessity for EMG has not been established. Submitted reports have not demonstrated any symptoms or clinical findings to suggest any cervical radiculopathy or entrapment syndrome. The EMG BILATERAL UPPER EXTREMITY is not medically necessary and appropriate.

**EMG BILATERAL LOWER EXTREMITY:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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

**Decision rationale:** This female sustained an injury on 1/30/13 while employed by [REDACTED] [REDACTED] Requests under consideration include EMG BILATERAL UPPER EXTREMITY, EMG BILATERAL LOWER EXTREMITY, and PHYSICAL THERAPY 3 X 6 RIGHT ARM/ SHOULDER. Report of 6/28/13 from the provider noted patient with right arm and low back pain, right lower extremity pain and hip pain. The provider is awaiting the MRI reports from Kaiser. Exam noted cervical spine has normal appearance; negative Spurling's test; negative tenderness over the musculature; negative spasms; motor exam of 5/5 to all upper extremities muscle groups with intact DTRs 2+; lumbar spine has antalgic gait; negative tenderness of par lumbar and par thoracic musculature; positive tenderness in the posterior superior iliac spine region; negative SI joints; negative muscle spasm; motor testing 5/5 to all muscle groups; walking on heels without difficulty; DTRs 2+; negative SLR; normal range of lumbar spine. Diagnoses included cervical strain; radiculitis right upper extremity; right arm pain; low back pain; radiculitis right lower extremity; and degenerative joint disease right hip. Treatment included Nucynta, Prilosec; Anaprox; EMG nerve conduction studies; continue PT 3x6 and awaiting MRI results. Per MTUS Guidelines, without specific symptoms or neurological compromise consistent with radiculopathy, foraminal or spinal stenosis, medical necessity for EMG has not been established. Submitted reports have not demonstrated any symptoms or clinical findings to suggest any cervical radiculopathy or entrapment syndrome. The EMG BILATERAL LOWER EXTREMITY is not medically necessary and appropriate.

**PHYSICAL THERAPY 3 X 6 RIGHT ARM/SHOULDER:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

**Decision rationale:** Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and work status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for 9-10 visits of physical therapy with fading of treatment to an independent self-directed home program. The employee has received more than the amount of therapy sessions recommended per the Guidelines without demonstrated evidence of functional improvement to allow for additional therapy treatments. The PHYSICAL THERAPY 3 X 6 RIGHT ARM/ SHOULDER is not medically necessary and appropriate.