

Case Number:	CM13-0045214		
Date Assigned:	12/27/2013	Date of Injury:	03/20/2013
Decision Date:	04/18/2014	UR Denial Date:	10/31/2013
Priority:	Standard	Application Received:	10/31/2013

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 Orthopaedic Surgery, 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 50 year-old female accounting technician sustained an industrial injury on 3/20/13 when she slipped on an oily substance and fell. Initial evaluation and management was provided on 3/26/13 with a diagnosis of lumbar and shoulder sprain. Conservative treatment was initiated with heat/cold, back support, back cushion and physical therapy. The initial chiropractic consult on 9/24/13 cited constant dull to sharp neck pain radiating to the shoulders, right shoulder pain, and lower back pain radiating to the buttocks. Pain was increased with activity and relieved with medications and rest. Past medical history was positive for multiple sclerosis. Some difficulty was reported with activities of daily living relative to dressing, lifting, carrying, bending, pushing, pulling, and doing household chores. Exam findings documented restricted and painful spinal range of motion, cervical and lumbar paraspinal tenderness, bilateral upper trapezius tenderness, decreased and painful right shoulder range of motion, right shoulder and Acromioclavicular joint tenderness, positive cervical mechanical test, positive right shoulder impingement test, positive bilateral straight leg raise, decreased bilateral upper and lower extremity sensation, 4/5 motor strength in all upper and lower extremity muscle groups, and normal deep tendon reflexes. The diagnosis was cervical and lumbar sprain/strain with radiculopathy, right shoulder internal derangement, and post-surgical right shoulder with residual pain. The treatment plan included physical therapy three times four, spinal and right shoulder x-rays, bilateral upper and lower extremity Electromyography / nerve conduction velocities, functional capacity evaluation, and medication and orthopedic referrals. The patient was temporarily totally disabled for six to eight weeks. The 10/29/13 progress report documented constant moderate to severe cervical and right shoulder pain and constant moderate lower back pain. Objective findings documented +3 cervical and lumbar paraspinal muscle tenderness and spasms with a positive cervical compression test. Global +3 right shoulder tenderness was

documented with a positive impingement sign. The treatment diagnosis was unchanged. The 10/31/13 utilization review decision recommended that the 9/24/13 request for twelve physical therapy sessions be certified with modification to eight sessions consistent with Medical Treatment Utilization Schedule (MTUS) guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

ELECTROMYOGRAPHY EMG OF THE BILATERAL 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): 178, 182..

Decision rationale: Under consideration is a request for bilateral upper extremity Electromyography. The California Medical Treatment Utilization Schedule (MTUS) guidelines indicate that Electromyography is recommended to clarify nerve root dysfunction in cases of suspected disc herniation pre-operatively or before epidural injection. Guidelines state that electromyography (EMG), and nerve conduction velocities (NCV), including Hoffmann Reflex tests, may help identify subtle focal neurological dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. Guideline criteria have not been met. There are no subjective or objective findings suggestive of a focal neurologic dysfunction to support the medical necessity of electrodiagnostic testing. The neurologic exam documents globally decreased sensation and strength over both the upper and lower extremities and normal deep tendon reflexes. There are no clear radicular or peripheral patterns documented on the initial visit and no subsequent documentation of any radicular or peripheral patterns. There are no provocative signs documented consistent with nerve root pathology or involvement. Therefore, this request for bilateral upper extremity Electromyography (EMG) is not medically necessary.

ELECTROMYOGRAPHY EMG OF THE LOWER 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): 303-304.

Decision rationale: Under consideration is a request for lower extremity Electromyography (EMG). The California Medical Treatment Utilization Schedule (MTUS) do not recommend Electromyography (EMG) to diagnosis lumbosacral strain. Electromyography (EMG), including Hoffmann Reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. Guideline criteria have not been met. There are no subjective or objective findings suggestive of a focal neurologic dysfunction to

support the medical necessity of electrodiagnostic testing. The neurologic exam documented globally decreased sensation and strength over both the upper and lower extremities and normal deep tendon reflexes. There are no clear radicular or peripheral patterns documented on the initial visit and no subsequent documentation of any radicular or peripheral patterns. Therefore, this request for lower extremity Electromyography (EMG) is not medically necessary.

NERVE CONDUCTION STUDY NCS OF THE BILATERAL UPPER EXTREMITY:
Upheld

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

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

Decision rationale: Under consideration is a request for bilateral upper extremity nerve conduction study. The California Medical Treatment Utilization Schedule (MTUS) guidelines indicate nerve conduction velocities (NCV), including Hoffmann Reflex tests, may help identify subtle focal neurological dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. Guideline criteria have not been met. There are no subjective or objective findings suggestive of a focal neurologic dysfunction to support the medical necessity of electrodiagnostic testing. The neurologic exam documented globally decreased sensation and strength over both the upper and lower extremities and normal deep tendon reflexes. There are no clear radicular or peripheral patterns documented on the initial visit and no subsequent documentation of any radicular or peripheral patterns. There are no provocative signs documented consistent with nerve root pathology or involvement. Therefore, this request for bilateral upper extremity nerve conduction study is not medically necessary.

NERVE CONDUCTION STUDY NCS OF THE LOWER EXTREMITY: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) LOW BACK - LUMBAR & THORACIC, NERVE CONDUCTION STUDIES (NCS)

Decision rationale: Under consideration is a request for lower extremity nerve conduction study. The California Medical Treatment Utilization Schedule (MTUS) do not provide recommendations for nerve conduction study in low back injuries. The Official Disability Guidelines do not recommend nerve conduction studies for low back complaints and state there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. The patient has been diagnosed with lumbar radiculopathy, however there are no supporting subjective or clinical exam findings to support the diagnosis of radiculopathy. Given the absence of guideline support and clinical evidence of

neurologic dysfunction, this request for lower extremity nerve conduction study is not medically necessary.

PHYSICAL THERAPY 3 TIMES 4 FOR THE CERVICAL RIGHT SHOULDER/LUMBAR: Upheld

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

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

Decision rationale: Under consideration is a request for physical therapy 3x4, cervical, right shoulder, and lumbar. The California Medical Utilization Schedule (MTUS) guidelines indicate that physical therapy for chronic pain patients should be focused on active therapies and generally recommend eight to ten visits of physical therapy for chronic pain patients. The 9/24/13 request for twelve physical therapy sessions was certified with modification to eight sessions in utilization review. There is no compelling reason submitted by the treating physician to support the medical necessity of treatment beyond guidelines. There were no specific functional treatment goals outlined to be addressed by physical therapy. Therefore, this request for physical therapy three times four for the cervical, right shoulder, and lumbar regions is not medically necessary.