

Case Number:	CM13-0049406		
Date Assigned:	06/20/2014	Date of Injury:	06/03/2013
Decision Date:	08/05/2014	UR Denial Date:	10/03/2013
Priority:	Standard	Application Received:	11/07/2013

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 Preventative Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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 patient is a 58 year old employee with date of injury of 6/3/2013. Medical records indicate the patient is undergoing treatment for post-concussion syndrome; cervical disk herniation with myelopathy; lumbar disc displacement without myelopathy; bursitis and tendinitis of the bilateral shoulders; bilateral rotator cuff sprain/strain. Subjective complaints include neck, bilateral shoulder and low back pain. Objective findings include 3+ spasm and tenderness to the bilateral paraspinal muscles through C3-C7 and bilateral suboccipital muscles; cervical range of motion was diminished; axial compression test was positive bilaterally for neurological compromise; distraction test positive bilateral; shoulder depression test positive bilaterally; lumbar spine 3+ spasm and tenderness to the bilateral paraspinal muscles from L3-S1; Kemp's test positive bilaterally; Achilles reflexes decreased; superspinous test was positive bilaterally. Treatment has consisted of 19 sessions of chiropractic care; QFCE topical compounded medications, Advil, acupuncture, PT and a urine toxicology screen. The utilization review determination was rendered on 10/2/2013 recommending non-certification of Follow-Up Visit or Equivalent with ROM Measurement and Patient Education; Work Hardening Program X 6 Visits Including Additional Therapy, Electrical Muscle Stimulation to The Cervical Spine, Infrared to The Lumbar Spine, Left Shoulder Theraband (Moderate Resist, 10 Reps, 5 Sets); Electromyogram (EMG) of the upper extremities; Nerve Conduction Velocity (NCV) of the upper extremities and Nerve Conduction Study (NCS) of the bilateral lower extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

Consultation: Follow-Up Visit or Equivalent with ROM Measurement and Patient Education: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation ODG.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 31-37, Chronic Pain Treatment Guidelines Official Disability Guidelines (ODG) Low Back, Range of Motion. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Range of Motion.

Decision rationale: The MTUS states, "Physical Impairments (e.g., joint ROM, muscle flexibility, strength, or endurance deficits): Include objective measures of clinical exam findings. ROM should be in documented in degrees". In the ACOEM physical examination portion it states Muscle testing and range of motion testing (ROM) are integral parts of a physical examination. This can be done either manually, or with computers or other testing devices. It is the treating physician's prerogative to perform a physical examination with or without muscle testing and ROM devices. However, in order to bill for this sort of test as a stand-alone diagnostic procedure, there must be medical necessity above and beyond the usual requirements of a medical examination, and the results must significantly impact the treatment plan. Muscle testing and range of motion testing as stand-alone procedures would rarely be needed as part of typical injury treatment. In this case, there is no evidence that the ROM muscle tests are clinically necessary and relevant in developing a treatment plan. While the ACOEM Guidelines do not comment specifically on this issue, other than to recommend a thorough history and physical examination, for which no computerized devices are recommended for measuring room or muscle testing. The treating physician did not provide specific rationale for a follow-up visit or equivalent with room measurement and patient education. As such the request is not medically necessary.

Therapy: Work Hardening Program X 6 Visits Including Additional Therapy, Electrical Muscle Stimulation to The Cervical Spine, Infrared to The Lumbar Spine, Left Shoulder Theraband (Moderate Resist, 10 Reps, 5 Sets): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 299. Decision based on Non-MTUS Citation ODG.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Work conditioning/work hardening Page(s): 125-126. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic), Work conditioning/work hardening.

Decision rationale: (1) Work related musculoskeletal condition with functional limitations precluding ability to safely achieve current job demands, which are in the medium or higher demand level (i.e., not clerical/sedentary work). An FCE may be required showing consistent results with maximal effort, demonstrating capacities below an employer verified physical demands analysis (PDA).(2) After treatment with an adequate trial of physical or occupational

therapy with improvement followed by plateau, but not likely to benefit from continued physical or occupational therapy, or general conditioning.(3) Not a candidate where surgery or other treatments would clearly be warranted to improve function.(4) Physical and medical recovery sufficient to allow for progressive reactivation and participation for a minimum of 4 hours a day for three to five days a week.(5) A defined return to work goal agreed to by the employer & employee:(a) A documented specific job to return to with job demands that exceed abilities, OR(b) Documented on-the-job training(6) The worker must be able to benefit from the program (functional and psychological limitations that are likely to improve with the program). Approval of these programs should require a screening process that includes file review, interview and testing to determine likelihood of success in the program.(7) The worker must be no more than 2 years past date of injury. Workers that have not returned to work by two years post injury may not benefit.(8) Program timelines: Work Hardening Programs should be completed in 4 weeks consecutively or less.(9) Treatment is not supported for longer than 1-2 weeks without evidence of patient compliance and demonstrated significant gains as documented by subjective and objective gains and measurable improvement in functional abilities.(10) Upon completion of a rehabilitation program (e.g. work hardening, work conditioning, outpatient medical rehabilitation) neither re-enrollment in nor repetition of the same or similar rehabilitation program is medically warranted for the same condition or injury.The treating physician did not provide the necessary documentation to meet the above guidelines and did not provide a "defined return to work goal agreed to by the employer & employee." "Treatment is not supported for longer than 1-2 weeks without evidence of patient compliance and demonstrated significant gains as documented by subjective and objective gains and measurable improvement in functional abilities". As such, the requests for work hardening program x 6 visits including additional therapy, electrical muscle stimulation to the cervical spine, infrared to the lumbar spine, left shoulder theraband (moderate resist), 10 REPS, 5 SETSIS not medically necessary.

Nerve Conduction Velocity (NCV) of the upper extremities: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177, 182. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain and Neck, Electrodiagnostic testing (EMG/NCS).

Decision rationale: ACOEM States "Appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful." ODG states "Recommended needle EMG or NCS, depending on indications. Surface EMG is not recommended. Electromyography (EMG) and Nerve Conduction Studies (NCS) are generally accepted, well-established and widely used for localizing the source of the neurological symptoms and establishing the diagnosis of focal nerve entrapments, such as carpal tunnel syndrome or radiculopathy, which may contribute to or coexist with CRPS II (causalgia), when testing is performed by appropriately trained neurologists or physical medicine and rehabilitation physicians (improperly performed testing by other providers often gives inconclusive results). As CRPS II occurs after partial injury to a nerve, the diagnosis of the initial

nerve injury can be made by electrodiagnostic studies". ODG additionally states that "In contrast, dissociation of NCS and EMG results into separate reports is inappropriate unless specifically explained by the physician. Performance and/or interpretation of NCSs separately from that of the needle EMG component of the test should clearly be the exception (e.g. when testing an acute nerve injury) rather than an established practice pattern for a given practitioner. (AANEM, 2009)". The treating physician has not provided clinical documentation of focal nerve entrapments (cervical radiculopathy and/or Carpal tunnel syndrome) and has not documented a trial and failure of conservative treatment. . As such the request for nerve conduction velocity (NCV) of the upper extremities is not medically necessary.

Electromyogram (EMG) of the bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 58-59, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Medical Fee Schedule.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Back, pages 303, 309; Official Disability Guidelines (ODG) Pain, Electrodiagnostic testing (EMG/NCS).

Decision rationale: ACOEM states "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." ODG states In the Low Back Chapter and Neck Chapter, "NCS is not recommended, but EMG is recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. Electrodiagnostic studies should be performed by appropriately trained Physical Medicine and Rehabilitation or Neurology physicians. See also Monofilament testing." ODG additionally states that "In contrast, dissociation of NCS and EMG results into separate reports is inappropriate unless specifically explained by the physician. Performance and/or interpretation of NCSs separately from that of the needle EMG component of the test should clearly be the exception (e.g. when testing an acute nerve injury) rather than an established practice pattern for a given practitioner. (AANEM, 2009)". The treating physician does not document additional neurologic findings to justify an EMG at this time such as sensory deficits in a dermatomal distribution or peripheral nerve distribution. As such the request for EMG of the bilateral lower extremities is not medically necessary.

Nerve Conduction Study (NCS) of the bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 58-59. Decision based on Non-MTUS Citation Official Medical Fee Schedule.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental

Medicine (ACOEM), 2nd Edition, (2004) Back, pages 303, 309; Official Disability Guidelines (ODG) Pain, Electrodiagnostic testing (EMG/NCS).

Decision rationale: ACOEM states "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." ODG states, in the Low Back Chapter and Neck Chapter, "NCS is not recommended, but EMG is recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. Electrodiagnostic studies should be performed by appropriately trained Physical Medicine and Rehabilitation or Neurology physicians. See also Monofilament testing." ODG additionally states that, "In contrast, dissociation of NCS and EMG results into separate reports is inappropriate unless specifically explained by the physician. Performance and/or interpretation of NCSs separately from that of the needle EMG component of the test should clearly be the exception (e.g. when testing an acute nerve injury) rather than an established practice pattern for a given practitioner. (AANEM, 2009)". The treating physician does not document additional neurologic findings to justify a EMG at this time such as sensory deficits in a dermatomal distribution or peripheral nerve distribution. As such the request for nerve conduction study (NCS) of the bilateral lower extremities is not medically necessary.

Electromyogram (EMG) of the upper extremities: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177, 182. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain and Neck, Electrodiagnostic testing (EMG/NCS).

Decision rationale: ACOEM States "Appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful." ODG states "Recommended needle EMG or NCS, depending on indications. Surface EMG is not recommended. Electromyography (EMG) and Nerve Conduction Studies (NCS) are generally accepted, well-established and widely used for localizing the source of the neurological symptoms and establishing the diagnosis of focal nerve entrapments, such as carpal tunnel syndrome or radiculopathy, which may contribute to or coexist with CRPS II (causalgia), when testing is performed by appropriately trained neurologists or physical medicine and rehabilitation physicians (improperly performed testing by other providers often gives inconclusive results). As CRPS II occurs after partial injury to a nerve, the diagnosis of the initial nerve injury can be made by electrodiagnostic studies". ODG additionally states that "In contrast, dissociation of NCS and EMG results into separate reports is inappropriate unless specifically explained by the physician. Performance and/or interpretation of NCSs separately from that of the needle EMG component of the test should clearly be the exception (e.g. when testing an acute nerve injury) rather than an established practice pattern for a given practitioner. (AANEM, 2009)". The treating physician has not provided clinical documentation of focal nerve

entrapments (cervical radiculopathy and/or Carpal tunnel syndrome) and has not documented a trial and failure of conservative treatment. As such the request for EMG of the bilateral upper extremities is not medically necessary.