

Case Number:	CM13-0064061		
Date Assigned:	01/03/2014	Date of Injury:	10/11/2011
Decision Date:	05/09/2014	UR Denial Date:	12/04/2013
Priority:	Standard	Application Received:	12/11/2013

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:

According to the records made available for review, this is a 47-year-old male with a 10/11/11 date of injury, left shoulder arthroscopy 9/27/13. At the time (11/22/13) of request for authorization for EMG of bilateral upper extremities and Continuation of Physical Therapy, there is documentation of subjective (worsening pain with numbness and tingling) and objective (positive Spurling's test bilaterally, diminished deep tendon reflexes bilaterally for all reflexes with weakness in reported as 4/5 bilaterally from shoulders to fingers, and decreased sensation for all dermatomes) findings, imaging findings (MRI Cervical Spine (11/11/12) report revealed C4-5 disc 3-4 mm midline disc bulge indenting the anterior portion of the cervical subarachnoid space causing 10% decrease in anterior-posterior sagittal diameter of cervical canal with the neural foramina patent), current diagnoses (cervical disc degeneration, cervical radiculopathy at C4-5, cervical strain, and left shoulder impingement syndrome/rule out shoulder arthroscopy), and treatment to date (activity modification, medications, and 12 sessions of post operative physical therapy). Regarding EMG, there is no documentation of a discrepancy in imaging and that the etiology of the radicular symptoms is not explained by MRI. Regarding continuation of physical therapy, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services with previous post operative physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG OF BILATERAL UPPER EXTREMITIES: 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, Chapter 10 Elbow Disorders (Revised 2007) Page(s): 177 33. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Electrodiagnostic studies (EDS).

Decision rationale: MTUS reference to ACOEM identifies documentation of subjective/objective findings consistent with radiculopathy/nerve entrapment that has not responded to conservative treatment, as criteria necessary to support the medical necessity of EMG/NCV. ODG identifies that EMG is useful in cases where clinical findings are unclear; there is a discrepancy in imaging, or to identify other etiologies of symptoms. Within the medical information available for review, there is documentation of diagnoses of cervical disc degeneration, cervical radiculopathy at C4-5, and cervical strain. In addition, there is documentation of subjective/objective findings consistent with radiculopathy/nerve entrapment that has not responded to conservative treatment. However, given documentation of imaging findings (MRI Cervical Spine revealed C4-5 disc 3-4 mm midline disc bulge indenting the anterior portion of the cervical subarachnoid space causing 10% decrease in anterior-posterior sagittal diameter of cervical canal with the neural foramina patent), there is no documentation of a discrepancy in imaging and that the etiology of the radicular symptoms is not explained by MRI. Therefore, based on guidelines and a review of the evidence, the request for EMG of bilateral upper extremities is not medically necessary.

CONTINUATION OF PHYSICAL THERAPY: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

Decision rationale: MTUS Postsurgical Treatment Guidelines identifies up to 24 visits of post-operative physical therapy over 14 weeks and post-surgical physical medicine treatment period of up to 6 months. In addition, MTUS Postsurgical Treatment Guidelines identifies that the initial course of physical therapy following surgery is half the number of sessions recommended for the general course of therapy for the specified surgery. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of a diagnosis of left shoulder impingement syndrome/rule out shoulder arthroscopy. In addition, there is documentation of status post left shoulder arthroscopy on 9/27/13. Furthermore, there is documentation of 12 sessions of post operative physical therapy sessions completed to date. However, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a

reduction in the use of medications or medical services with previous post operative physical therapy. Therefore, based on guidelines and a review of the evidence, the request for Continuation of Physical Therapy is not medically necessary.