

Case Number:	CM14-0002959		
Date Assigned:	01/24/2014	Date of Injury:	09/23/2013
Decision Date:	06/19/2014	UR Denial Date:	01/03/2014
Priority:	Standard	Application Received:	01/08/2014

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, has a subspecialty in Sports Medicine and is licensed to practice in Texas. 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:

The injured worker is a 52-year-old female who reported an injury on 09/23/2013. The mechanism of injury was not provided in the clinical documentation submitted. The clinical note dated 01/16/2014 reported the injured worker complained of limitations with range of motion and pain following an injection to the right shoulder. The injured worker underwent MRI which was not available to review. The physical exam the provider noted cervical spine tenderness. The provider noted spasms were present. The provider noted the injured worker to have restriction in her range of motion. Motor strength and sensation is grossly intact. The provider also noted the right shoulder to have tenderness to palpation. The provider also noted the range of motion to the right shoulder is decreased in flexion and abduction. The provider also noted tenderness to palpation of the elbows with positive Tinel's on the right elbow. The injured worker has diagnoses of cervical spine strain, right shoulder impingement syndrome, bilateral epicondylitis, right ulnar neuropathy at the elbow, and lumbar strain. The injured worker has currently undergone 18 sessions of physical therapy. The provider requested the injured worker to undergo additional physical therapy to the right shoulder 3 times a week for 4 weeks to fully mobilize the shoulder to be able to return to motion with functional limits. The provider is also requesting an EMG of the upper extremities and NCS of the upper extremities. The request for authorization was provided and submitted on 01/16/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

PT 3X WK FOR 4 WKS, 12 TOTAL FOR RIGHT SHOULDER: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, PHYSICAL MEDICINE, 99

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

Decision rationale: The request for physical therapy 3 times a week for 4 weeks, 12 total for the right shoulder is non-certified. The injured worker reported continuation of pain and limitation of range of motion to the right shoulder after an injection. The injured worker underwent an MRI which the report has not been submitted for review. The California MTUS Guidelines note active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. The guidelines also note active therapy requires an internal effort by the individual to complete a specific exercise or task. The Guidelines also note the goal of physical therapy is to allow fading of physical therapy. The guidelines note neuralgia and myalgia, they allow for 8 to 10 visits of physical therapy. There was a lack of clinical documentation indicating the efficacy of the physical therapy. The provider's rationale for additional physical therapy was unclear. In addition, the request for 12 additional physical therapy sessions to the right shoulder exceeds the guideline's limitations of 8-10 visits of physical therapy. Therefore, the request for physical therapy 3 times a week for 4 weeks, total of 12 visits for the right shoulder is not medically necessary or appropriate.

EMG OF UPPER EXTREMITIES: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM GUIDELINES, CHAPTER 10, ELBOW DISORDERS, SPECIAL STUDIES AND DIAGNOSTIC AND TREATMENT CONSIDERATIONS, ELECTROMYOGRAPHY (EMG),

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 42-43.

Decision rationale: The request of EMG for the upper extremities is non-certified. The injured worker complained of continued pain with limitation of range of motion after an injection to the right shoulder. The injured worker underwent MRI for which was not available for review. The American College of Occupational and Environmental Medicine notes recommendation of an EMG study if cervical radiculopathy is suspected as a cause of lateral arm pain and that condition has been present for at least 6 weeks. The documentation provided indicated the injured worker did have decreased range of motion in the right shoulder and tenderness on palpation of the right shoulder. The provider's rationale for the request of an EMG of the upper extremity was unclear. There was lack of documentation indicating the injured worker had problems with the left shoulder. Therefore, the request for EMG of the upper extremities is not medically necessary or appropriate.

NCS OF UPPER EXTREMITIES: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM GUIDELINES, CHAPTER 10, ELBOW DISORDERS, ULNAR NERVE ENTRAPMENT, NERVE CONDUCTIONS STUDIES (NCS),

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and upper Back, Nerve conduction studies.

Decision rationale: The request for NCS of the upper extremities is non-certified. The injured worker complained of continuous pain and limitation of range of motion to the right shoulder following an injection of the right shoulder. The injured worker underwent MRI of the right shoulder; clinical documentation has not been submitted for review. The Official Disability Guidelines do not recommend nerve conduction studies to demonstrate radiculopathy if radiculopathy has already been clearly identified by an EMG and obvious clinical signs, were recommended if the EMG is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic process if other diagnosis may be likely based on clinical exam. There is minimal justification for performing nerve conduction studies when the patient is already presumed to have symptoms on the basis of radiculopathy. Therefore, the request for NCS of the upper extremities is not medically necessary or appropriate.