

Case Number:	CM14-0116421		
Date Assigned:	08/04/2014	Date of Injury:	01/27/2011
Decision Date:	09/23/2014	UR Denial Date:	07/14/2014
Priority:	Standard	Application Received:	07/24/2014

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 Family Medicine 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 is a 43 year old male patient who reported an industrial injury on 1/27/2011; over 3 months ago to the RUE attributed to the performance of his job tasks. The patient was diagnosed with right knee internal derangement; right shoulder impingement syndrome; and s/p excision of right scapula lipoma. The patient is assessed as TTD. The patient has a QME evaluation that reported that the right shoulder required no further treatment. The QME also recommends home exercises for the cervical spine; judicious use of NSAIDs; and no ESWT. The patient complained of right shoulder pain and right knee pain. The objective findings on examination included right shoulder lipoma scar; reduced ROM; weakness to overhead reaching; right knee tenderness to the MJL and LJJ; swelling/effusion present; positive grind test; hamstring tender; There was no diagnosis to the cervical spine. The patient was documented to have received six (6) additional recent sessions of PT directed to the shoulder to reestablish a self directed home exercise program.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy to the right arm, 2 times a week for 4 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) On Line Treatment Guidelines (<http://www.odg-twc.com/odgwc/shoulder.htm>), Physical Therapy for the shoulder.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203-204. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 6 page 114; Official Disability Guidelines (ODG) shoulder chapter--PT.

Decision rationale: The patient has received 6 recent sessions to date on this industrial claim with noted improvement, whereas the CA MTUS recommends up to ten (10) sessions for the treatment of the cited diagnoses attributed to the DOI. The patient more sessions of physical therapy directed to the right upper extremity than recommended by the MTUS. There is no medical necessity demonstrated for an additional 2x4 sessions of PT for the cited diagnoses. The requesting provider has provided no objective evidence to support the medical necessity of additional sessions of OT/PT as opposed to a self directed home exercise program for the strengthening and conditioning of the right shoulder. The patient is noted to be able to participate in HEP. The patient has been provided with prior sessions of PT and the request for additional sessions of PT has significantly exceeded the number recommended by the CA MTUS for the treatment of the stated diagnoses. The patient has been documented with improvement of strength and range of motion to the right shoulder. The additional strengthening prescribed can be accomplished in HEP as recommended. The patient had physical therapy to the shoulder status post lipoma removal. The patient had PT for shoulder impingement and the QME indicated that the shoulder required no further treatment. There are no diagnoses that could not be addressed with HEP. The CA MTUS recommends up to ten (10) sessions of physical therapy over eight (8) weeks for the rehabilitation of the shoulder subsequent to the diagnosis of sprain/strain or impingement. There is no subjective/objective evidence provided to support the medical necessity of the additional sessions of PT over the recommended self-directed home exercise program once the total number of sessions recommended by the CA MTUS has been completed. The documented objective findings are consistent with the level where the patient is able to use the exercises learned in PT and apply them in a home exercise program. Given the above the request is not medically necessary.

EMG (electromyography) studies, bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 261-262. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (http://www.odg-twc.com/odgwc/Carpal_Tunnel.htm).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints Page(s): 303; 301, 298; 48; 178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck and upper back-electromyography; carpal tunnel syndrome-EDS.

Decision rationale: The request for the authorization of the EMG of the bilateral upper extremities is not supported with sufficient objective clinical findings that would contribute to the future treatment plan of the patient and is not supported by any changes in objective findings documented on examination. There are no documented progressive neurological deficits to support the medical necessity of Electrodiagnostic studies. The evaluation to rule out a peripheral

nerve entrapment or cervical radiculopathy is not supported with the documented objective findings documented on examination. There is no demonstrated medical necessity for the requested Electrodiagnostic studies without the failure of conservative treatment. There are no objective or subjective findings documented that require immediate Electrodiagnostic studies as no surgical intervention is contemplated and the patient has not failed injections and HEP. The Electrodiagnostic studies were ordered due to continued right shoulder pain. There are no documented left upper extremity symptoms. There are no documented changes in the neurological status of the patient that would require Electrodiagnostic studies. The clinical narrative documented that the Electrodiagnostic studies were ordered as screening studies. There is no demonstrated medical necessity for the requested EMG screening examination. The provider has documented no objective findings on examination to be further evaluated with Electrodiagnostic studies prior to the provision of conservative treatment. There are subjective findings; however, there are no significant neurological deficits documented that require Electrodiagnostic studies. The Electrodiagnostic test is ordered as a screening test. There is no contemplated surgical intervention for a cervical radiculopathy or peripheral nerve entrapment neuropathy. There is no demonstrated impending surgical intervention being contemplated and the patient has not completed ongoing conservative care. There is no objective evidence that the patient has median or ulnar entrapment neuropathy that would qualify for surgical intervention. The EMG is for diagnostic purposes for cervical radiculopathy or peripheral nerve compression neuropathy, which are not documented by objective findings. The EMG would be helpful to assess the medical necessity of a peripheral nerve decompression; however, the patient has not been demonstrated to have failed conservative treatment. There is no medical necessity for the requested Electrodiagnostic studies for the evaluation of the patient at this time prior to the provision of conservative treatment. The current clinical objective findings did not demonstrate a significant change in the clinical status of the patient as to nerve entrapment neuropathies and there was not rationale for the requested Electrodiagnostic study other than to "rule out" a nerve compression neuropathy or a nerve root impingement neuropathy with a screening study. There were no documented clinical changes or objective findings to support the medical necessity of an initial EMG/NCS study. The EMG would only be necessary to evaluate for the medical necessity of surgical intervention for moderate to severe symptoms with objective findings documented on examination. The criteria recommended by the CA MTUS, the ACOEM Guidelines or the Official Disability Guidelines for the use of Electrodiagnostic studies for the BUEs were not documented by the requesting provider. There was no demonstrated objective evidence such as a neurological deficit or change in status is that supports the authorization of EMG studies. There is no demonstrated medical necessity to evaluate for a bilateral upper extremity radiculopathies or peripheral neuropathies based on the objective findings documented. Therefore the request is not medically necessary.

NCV (nerve conduction velocity) studies, bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 261-262. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (http://www.odg-twc.com/odgwc/Carpal_Tunnel.htm).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand

Complaints, Chapter 12 Low Back Complaints Page(s): 261-262; 303,301, 298; 178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck and upper back-EMG; carpal tunnel syndrome EDS.

Decision rationale: The request for the authorization of the NCS of the bilateral upper extremities is not supported with sufficient objective clinical findings that would contribute to the future treatment plan of the patient and is not supported by any changes in objective findings documented on examination. There are no documented progressive neurological deficits to support the medical necessity of Electrodiagnostic studies. The evaluation to rule out a peripheral nerve entrapment or cervical radiculopathy is not supported with the documented objective findings documented on examination. There is no demonstrated medical necessity for the requested Electrodiagnostic studies without the failure of conservative treatment. There are no objective or subjective findings documented that require immediate Electrodiagnostic studies as no surgical intervention is contemplated and the patient has not failed injections and HEP. The Electrodiagnostic studies were ordered due to continued right shoulder pain. There are no documented left upper extremity symptoms. The QME recommended no further treatment to the right shoulder. There are no documented changes in the neurological status of the patient that would require Electrodiagnostic studies. The clinical narrative documented that the Electrodiagnostic studies were ordered as screening studies. There is no demonstrated medical necessity for the requested NCS screening examination. The provider has documented no objective findings on examination to be further evaluated with Electrodiagnostic studies prior to the provision of conservative treatment. There are subjective findings; however, there are no significant neurological deficits documented that require Electrodiagnostic studies. The Electrodiagnostic test is ordered as a screening test. There is no contemplated surgical intervention for a cervical radiculopathy or peripheral nerve entrapment neuropathy. There is no demonstrated impending surgical intervention being contemplated and the patient has not completed ongoing conservative care. There is no objective evidence that the patient has median or ulnar entrapment neuropathy that would qualify for surgical intervention. The NCS is for diagnostic purposes for cervical radiculopathy or peripheral nerve compression neuropathy, which are not documented by objective findings. The NCS would be helpful to assess the medical necessity of a peripheral nerve decompression; however, the patient has not been demonstrated to have failed conservative treatment. There is no medical necessity for the requested Electrodiagnostic studies for the evaluation of the patient at this time prior to the provision of conservative treatment. The current clinical objective findings did not demonstrate a significant change in the clinical status of the patient as to nerve entrapment neuropathies and there was not rationale for the requested Electrodiagnostic study other than to "rule out" a nerve compression neuropathy or a nerve root impingement neuropathy with a screening study. There were no documented clinical changes or objective findings to support the medical necessity of an initial NCS study. The EMG/NCS would only be necessary to evaluate for the medical necessity of surgical intervention for moderate to severe symptoms with objective findings documented on examination. The criteria recommended by the CA MTUS, the ACOEM Guidelines or the Official Disability Guidelines for the use of Electrodiagnostic studies for the BUEs were not documented by the requesting provider. There was no demonstrated objective evidence such as a neurological deficit or change in status that supports the authorization of NCS studies. There is no demonstrated medical necessity to evaluate for a bilateral upper extremity radiculopathies

or peripheral neuropathies based on the objective findings documented. Therefore the request is not medically necessary.

Orthopedic Re-Evaluation, within 6 weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, 2nd Edition (text, page 127).

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) chapter 7 page 127;.

Decision rationale: The request for authorization of a follow up consultation with the Orthopedic Surgeon, for the documented diagnoses and is not demonstrated to be medically necessary for the effects of the cited industrial injury. There are no documented objective findings by the requesting provider to support the medical necessity of a continued orthopedic treatment for the diagnoses documented. There is no documented surgical lesion to the shoulder or knee. There is no demonstrated medical necessity for the patient to continue with Orthopedics for the shoulder or knee for the provision of conservative treatment. The reports by the provider do not establish the medical necessity for continued orthopedic surgeon evaluation/treatment of the cited diagnoses of reported TTP/decreased ROM as effects of the reported industrial injury. The patient already has recommendations for future medical care which do not include surgical intervention.