

Case Number:	CM14-0152741		
Date Assigned:	09/22/2014	Date of Injury:	06/01/2012
Decision Date:	10/22/2014	UR Denial Date:	08/21/2014
Priority:	Standard	Application Received:	09/18/2014

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 Anesthesiology, has a subspecialty in Pain Management 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 51-year-old male with a 6/1/12 date of injury. At the time (8/7/14) of the request for authorization for EMG (Electromyography)/NCV (nerve conduction velocity) for the Bilateral Lower Extremities, EMG (Electromyography)/NCV (nerve conduction velocity) for the Bilateral Upper Extremities, and Physiotherapy Three times a Week for Four Weeks For the Cervical Spine, there is documentation of subjective (neck and lower back pain) and objective (spasm, tenderness, and guarding is noted in the paravertebral muscles of the cervical and lumbar spine along with decreased range of motion, decreased dermatomal sensation with pain is noted over the bilateral C6 and bilateral L5 dermatomes) findings, current diagnoses (cervical sprain/strain, lumbosacral radiculopathy, lumbar sprain/strain, cervical radiculopathy, and hip tendinitis/bursitis), and treatment to date (medication and chiropractic therapy).

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG (Electromyography) / NCV (nerve conduction velocity) for the Bilateral Lower Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 238. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES - ELECTROMYOGRAPHY

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Electrodiagnostic studies

Decision rationale: MTUS reference to ACOEM guidelines identifies documentation of focal neurologic dysfunction in patients with low back symptoms lasting more than three to four weeks, as criteria necessary to support the medical necessity of electrodiagnostic studies. ODG identifies documentation of evidence of radiculopathy after 1-month of conservative therapy, as criteria necessary to support the medical necessity of electrodiagnostic studies. In addition, ODG does not consistently support performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Within the medical information available for review, there is documentation of diagnoses of cervical sprain/strain, lumbosacral radiculopathy, lumbar sprain/strain, cervical radiculopathy, and hip tendinitis/bursitis. In addition, there is documentation of focal neurologic dysfunction in patients with low back symptoms lasting more than three to four weeks. However, there is no documentation of a rationale for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Therefore, based on guidelines and a review of the evidence, the request for EMG (Electromyography)/NCV (nerve conduction velocity) for the Bilateral Lower Extremities is not medically necessary.

EMG (Electromyography) / NCV (nerve conduction velocity) for the Bilateral Upper Extremities: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 238. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES - ELECTROMYOGRAPHY

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 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. Within the medical information available for review, there is documentation of diagnoses of cervical sprain/strain, lumbosacral radiculopathy, lumbar sprain/strain, cervical radiculopathy, and hip tendinitis/bursitis. In addition, there is documentation of subjective/objective findings consistent with radiculopathy/nerve entrapment that has not responded to conservative treatment. Therefore, based on guidelines and a review of the evidence, the request for EMG (Electromyography)/NCV (nerve conduction velocity) for the Bilateral Upper Extremities is medically necessary.

Physiotherapy Three times a Week for Four Weeks For the Cervical Spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM CHAPTER(PAIN, SUFFERING,

AND THE RESTORATION OF FUNCTION)OFFICIAL DISABILITY GUIDELINES- LOW BACK CHAPTER

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back, Physical therapy

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines support a brief course of physical medicine for patients with chronic pain not to exceed 10 visits over 4-8 weeks with allowance for fading of treatment frequency, with transition to an active self-directed program of independent home physical medicine/therapeutic exercise. 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. ODG recommends a limited course of physical therapy for patients with a diagnosis of radiculitis not to exceed 12 visits over 10 weeks. ODG also notes patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy) and when treatment requests exceeds guideline recommendations, the physician must provide a statement of exceptional factors to justify going outside of guideline parameters. Within the medical information available for review, there is documentation of diagnoses of cervical sprain/strain, lumbosacral radiculopathy, lumbar sprain/strain, cervical radiculopathy, and hip tendinitis/bursitis. However, it is not clear if this is a request for initial or additional (where physiotherapy provided to date may have already exceeded guidelines regarding frequency) physiotherapy. Therefore, based on guidelines and a review of the evidence, the request for Physiotherapy Three times a Week for Four Weeks for the Cervical Spine is not medically necessary.