Case Number:	CM14-0155205		
Date Assigned:	09/25/2014	**Date of Injury:**	06/17/2013
Decision Date:	10/27/2014	**UR Denial Date:**	08/26/2014
Priority:	Standard	**Application Received:**	09/22/2014

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 Internal Medicine, has a subspecialty in Nephrology 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:

The patient is a 62-year-old male who has submitted a claim for s/p left shoulder surgery for rotator cuff tendinopaty and possible repair, residual pain and stiffness at the level of the left shoulder, and discogenic problem and disc derangement or disc protrusion at the level of the cervical spine causing cervical radiculopathy associated with an industrial injury date of 6/17/2013.Medical records from 1/20/2014 up to 8/7/2014 were reviewed showing left shoulder pain with extensions to left side of cervical spine. Patient underwent a left rotator cuff arthropathy with full thickness rotator cuff repair with 22 documented post-op physical therapy over 2 months. Physical examination revealed tenderness and spasm over the level of C4-5, C5-6, and C6-7 with extensions to the posterior and anterior aspects of left shoulder. Cervical spine and left shoulder ROM were limited. Muscle testing showed 1+ weakness of resistive abduction of the left shoulder as well as 1+ weakness of resistive external rotation when compared to the right. Neurological examination indicated intact cranial nerves. Resistive biceps testing at the level of the left elbow showed 1+ weakness. Resistive dorsiflexion of the left wrist also showed 1+ weakness. As per PR dated 8/7/2014, the findings are indicative of possible involvement of C5-C6 and C6-C7 disc spaces and possible disc protrusion causing nerve root compression causing secondary weakness of these muscular elements.Treatment to date has included arthroscopy and physical therapy.Utilization review from 8/26/2014 denied the request for Therapy (Evaluation, Re-Evaluation, Exercise) 2 X 8 Cervical Spine and Left Shoulder, EMG Bilateral Upper Extremities, and NCV Bilateral Upper Extremities. Regarding therapy for cervical spine and left shoulder, the patient has undergone 32 sessions of therapy post-operatively and he is now 6 months from the time of surgery. Regarding the EMG and NCV, this patient does not have any significant radiculopathy because there was no obvious sensory distribution loss in C6 or C7 and there was no reflex loss.

IMR ISSUES, DECISIONS AND RATIONALES

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

Therapy (Evaluation, Re-Evaluation, Exercise) 2 X 8 Cervical Spine and Left Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99,Postsurgical Treatment Guidelines Page(s): 17.

Decision rationale: According to pages 98-99 of the CA MTUS Chronic Pain Medical Treatment Guidelines, active therapy is recommended for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Physical medicine guidelines allow for fading of treatment frequency from up to 3 visits per week to 1 or less plus active self-directed home physical medicine. Postsurgical treatment, arthroplasty, 24 visits over 8 weeks; Postsurgical physical medicine treatment period: 4 months. In this case, the patient underwent a left rotator cuff arthropathy with full thickness rotator cuff repair with 22 documented post-op physical therapy over 2 months. Physical examination revealed tenderness and spasm over the level of C4-5, C5-6, and C6-7 with extensions to the posterior and anterior aspects of the left shoulder. Cervical spine and left shoulder ROM were limited. However, the current request of 16 additional visits is beyond the recommended number of sessions as per guidelines. There was no documentation that the patient has been transitioning to a home exercise program. Therefore, the request for Therapy (Evaluation, Re-Evaluation, Exercise) 2 X 8 Cervical Spine and Left Shoulder is not medically necessary.

EMG 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 10 Elbow Disorders (Revised 2007) Page(s): 238.

Decision rationale: According to page 238 of the CA MTUS ACOEM Practice Guidelines, EMG is recommended if cervical radiculopathy is suspected as a cause of lateral arm pain or if severe nerve entrapment is suspected on the basis of physical examination and denervation atrophy is likely. Moreover, guidelines do not recommend EMG before conservative treatment. In this case, the patient's examination revealed tenderness and spasm over the level of C4-5, C5-6, and C6-7 with extensions to the posterior and anterior aspects of left shoulder. Cervical spine and left shoulder ROM were limited. Muscle testing showed 1+ weakness of resistive abduction of the left shoulder as well as 1+ weakness of resistive external rotation when compared to the

right. Resistive biceps testing at the level of the left elbow showed 1+ weakness. Resistive dorsiflexion of the left wrist also showed 1+ weakness. As per PR dated 8/7/2014, the findings are indicative of possible involvement of C5-C6 and C6-C7 disc spaces and possible disc protrusion causing nerve root compression causing secondary weakness of these muscular elements. The patient has utilized conservative therapy in the form of physical therapy. Cervical radiculopathy is suspected as a cause of lateral arm pain and weakness of the left arm, hence, EMG is a reasonable diagnostic option. However, there is no clear discussion why the asymptomatic contralateral extremity should also undergo testing. Therefore, the request for EMG Bilateral Upper Extremities is not medically necessary.

NCV 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 11 Forearm, Wrist, and Hand Complaints Page(s): 261-262. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Nerve Conduction Studies

Decision rationale: CA MTUS ACOEM Guidelines state that appropriate electrodiagnostic studies may help differentiate between carpal tunnel syndrome and other conditions, such as cervical radiculopathy. These include nerve conduction studies, or in more difficult cases, electromyography may be helpful. Moreover, ODG states that NCS is not recommended to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but is recommended if the EMG is not clearly consistent with radiculopathy. In this case, the patient does exhibit signs and symptoms of cervical radiculopathy. However, there is no available EMG for review. The results from an EMG should be reviewed first before an NCS be deemed necessary. Therefore the request for NCV Bilateral Upper Extremities is not medically necessary.