MAXIMUS Federal Services

Case Number:	CM14-0156338		
Date Assigned:	09/25/2014	Date of Injury:	04/27/2013
Decision Date:	12/24/2014	UR Denial Date:	09/15/2014
Priority:	Standard	Application Received:	09/24/2014

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 Physical Rehabilitation & Pain Management has a subspecialty in Interventional Spine 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 34 year old with an injury date on 4/27/13. The patient complains of right shoulder pain with weakness, intermittent clicking/catching, mostly daytime pain (occasional nighttime pain) per 7/30/14 report. Based on the 7/30/14 progress report provided by the treating physician, the diagnosis is previous subacromial decompression of right shoulder, rule out persistent labral tear. Exam on 7/30/14 showed "right shoulder range of motion slightly reduced, with abduction at 150/180 degrees." Patient's treatment history includes physical therapy, medications. The treating physician is requesting EMG right upper extremity, and physical therapy 3x week for 4 weeks. The utilization review determination being challenged is dated 9/15/14 and denies request due to lack of documentation of outcome from prior physical therapy sessions. The requesting physician provided treatment reports from 3/26/14 to 9/4/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG Right Upper Extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back (updated 08/04/2014) Electromyography (EMG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): EMG, 260-262.

Decision rationale: This patient presents with right shoulder pain and is s/p arthroscopic labral SLAP repair and subacromial decompression from 1/9/14. The treating physician has asked for EMG Right Upper Extremity on 7/30/14. The 7/2/14 report states patient had an EMG NCV in May of 2014 (original study not included in reports), but patient has continuing cervical radicular symptoms with parethesias down right arm. The treating physician wants a new EMG done, because patient "had pain and guarding and therefore not sure that the test was accurate" per 7/30/14 report, as the patient states "there were technical problems when they did that test." In reference to specialized studies of the neck, MTUS guidelines state that electromyography tests may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. "Appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful. NCS and EMG may confirm the diagnosis of CTS but may be normal in early or mild cases of CTS. If the EDS are negative, tests may be repeated later in the course of treatment if symptoms persist."In this case, the patient with radiculopathy and peripheral neuropathy which require electrodiagnostic studies to differentiate. Patient had a prior EMG (results not described in reports). The treating physician does not provide a sufficient rationale with documentation of original EMG results. A repeat EMG is not indicated without a sufficient rationale. Therefore, the request is not medically necessary.

Physical Therapy 3 x week for 4 weeks: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines Shoulder (update 08/27/2014) Physical Therapy.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26,27.

Decision rationale: This patient presents with right shoulder pain and is s/p arthroscopic labral SLAP repair and subacromial decompression from 1/9/14. The treating physician has asked for Physical Therapy 3x week for 4 weeks on 7/30/14. The patient had 3 postoperative physical therapy sessions. MTUS guidelines state for rotator cuff syndrome/Impingement syndrome and arthroscopic shoulder surgery, post surgical treatment of 24 visits over 14 weeks is recommended over a treatment period of 6 months. In this case, the patient had 3 postoperative physical therapy sessions (utilization review letter dated 9/15/14 states "3-6 sessions") and continued with persistent right shoulder pain. The patient appears to be outside the 6 month postoperative timeframe for physical therapy. However, considering patient's continuing range of motion deficits, and the fact that he only had 3 sessions of physical therapy, the requested 12 sessions appear reasonable for patient's ongoing chronic pain condition. The request is medically necessary.