

<b>Case Number:</b>	CM14-0070025		
<b>Date Assigned:</b>	07/14/2014	<b>Date of Injury:</b>	10/27/2011
<b>Decision Date:</b>	08/27/2014	<b>UR Denial Date:</b>	04/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/15/2014

### 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 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 55 year old male with an injury date on 10/27/2011. Based on the 03/24/2014 progress report provided by [REDACTED] the diagnoses are: 1. Status post left shoulder rotator cuff repair 3/5/2013. 2. History of right shoulder subacromial decompression (09/1990) 3. Cervical sprain/strain with advanced discogenic collapse at C6-C7 4. Lumbosacral sprain/strain without radiculopathy 5. Left-sided interscapular pain and weakness, unknown etiology 6. History of closed head trauma with memory loss, hearing, vision disturbance, gastrointestinal complaints, sleep disturbance as well as history of psychologic impairment namely depression and anxiety According to this report, the patient complains of low back pain, foot pain, and left shoulder pain that radiates to the upper back. Pain noted with palpation to the trapezius and rhomboid muscles and C4-C7 paraspinals muscles. Left shoulder range of motion limited. Cervical range of motion is slightly restricted. Deep tendon reflex of the biceps and triceps are diminished bilaterally. L'Hermite test is positive with pain bilaterally. The patient rated the pain as a constant 7/10, 8-9/10 at worsen and 4-5/10 at least. The pain is noted primary in the left scapula and not the shoulder that would radiate to the lower back .There were no other significant findings noted on this report. [REDACTED] is requesting: 1.EMG of the bilateral upper extremities 2. NCS of the bilateral upper extremities 3. 12 physical therapy session for the cervical spine and left shoulder. The utilization review denied the request on 04/17/2-14. [REDACTED] is the requesting provider, and provided treatment reports from 08/19/2013 to 06/09/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**EMG of the bilateral upper extremities:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

**Decision rationale:** According to the 03/24/2014 report by [REDACTED] this patient presents with low back pain, foot pain, and left shoulder pain that radiates to the upper back. The provider is requesting EMG of the bilateral upper extremities. The utilization review denial letter states without evidence of significant deficits suggestive of radiculopathy or peripheral entrapment, the testing is not indicated. Regarding electrodiagnostic studies, the ACOEM supports it for upper extremities to differentiate CTS vs. radiculopathy and other conditions. This patient has not had an EMG. Therefore, EMG of the bilateral upper extremities is medically necessary.

**12 Physical therapy sessions for the cervical spine and left shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

**Decision rationale:** According to the 03/24/2014 report by [REDACTED] this patient presents with low back pain, foot pain, and left shoulder pain that radiates to the upper back. The provider is requesting 12 sessions of physical therapy for the neck and left shoulder. The patient is status post left rotator cuff repair on 03/05/ 2013 and is outside of post-surgical time-frame and for therapy treatments. The utilization review denial letter states that the number of physical therapy sessions the claimant has completed is unclear and there were no evidence of objective and functional benefit. For physical medicine, the MTUS guidelines recommend for myalgia and myositis type symptoms 9-10 visits over 8 weeks. Review of available records show no therapy reports and there is no discussion regarding the patient's progress. If the patient did not have any recent therapy, a short course of therapy may be reasonable if the patient's symptoms are flared or the patient's function significantly declined. However, the provider does not discuss the patient's treatment history or the reasons for requested additional therapy. No discussion is provided as to why the patient is not able to perform the necessary home exercises. MTUS page 8 requires that the provider provide monitoring of the patient's progress and make appropriate recommendations. In addition, the requested 12 sessions exceed what is allowed by MTUS guidelines. Therefore, 12 Physical Therapy sessions for the cervical spine and left shoulder are not medically necessary.

**NCS of the bilateral upper extremities:** Overturned

**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): 262.

**Decision rationale:** According to the 03/24/2014 report by [REDACTED] this patient presents with low back pain, foot pain, and left shoulder pain that radiates to the upper back. The provider is requesting NCS of the bilateral upper extremities. The utilization review denial letter states without evidence of significant deficits suggestive of radiculopathy or peripheral entrapment, the testing is not indicated. Regarding electrodiagnostic studies, the ACOEM supports it for upper extremities to differentiate CTS vs. radiculopathy and other conditions. This patient has not had NCV studies. Therefore, NCS of the bilateral upper extremities is medically necessary.