

Case Number:	CM14-0079398		
Date Assigned:	07/18/2014	Date of Injury:	04/08/2010
Decision Date:	09/18/2014	UR Denial Date:	05/20/2014
Priority:	Standard	Application Received:	05/29/2014

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 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:

This is a male patient with the date of injury of April 8, 2010. A Utilization Review was performed on May 20, 2014 and recommended non-certification of EMG (Electromyography) /NCS (nerve conduction study) bilateral upper and lower extremities, physical therapy 2 x 4, and consult psych. A PR-2 report dated May 1, 2014 identifies Subjective Complaints of bilateral shoulder, left wrist, left elbow, and left knee pain. Positive numbness and tingling of upper extremities bilaterally. Objective Findings identify decreased rotation, decreased abduction, and decreased flexion. Decreased range of motion right shoulder. Positive tenderness to palpation. Diagnoses identify bilateral shoulder impingement/post multi surgeries, left wrist CTS, left elbow bursitis/tendinitis, and left knee internal derangement, post-surgical, positive meniscal tear/DJD (degenerative joint disease). Treatment Plan identifies EMG/NCV bilateral upper and lower extremities, physical therapy 2 x 4, and referral to psych.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV BILATERAL UPPER AND LOWER EXTREMITIES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 177,178.
Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 178, 182, 303. Decision based on Non-

MTUS Citation ODG Neck Chapter, Electrodiagnostic Studies, Electromyography, Nerve Conduction Studies and Low Back Chapter, Electrodiagnostic Studies.

Decision rationale: Regarding the request for EMG/NCV of bilateral upper and lower extremities, Occupational Medicine Practice Guidelines state that the electromyography and nerve conduction velocities including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. Occupational Medicine Practice Guidelines additionally state that unequivocal objective findings that identify specific nerve compromise on the neurologic exam are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery. When a neurologic examination is less clear however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. They go on to state that electromyography may be useful to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than 3 to 4 weeks. ODG states that nerve conduction studies are not recommended for back conditions. They go on to state that there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Within the documentation available for review, there are no physical examination findings supporting a diagnosis of specific nerve compromise. Additionally, if such findings are present but have not been documented, there is no documentation that the patient has failed conservative treatment directed towards these complaints. In the absence of such documentation, but currently requested NCV of the lower extremities is not medically necessary.

PHYSICAL THERAPY 2X4: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELIENS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Physical Therapy.

Decision rationale: Regarding the request for physical therapy 2x4, California MTUS cites that "patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels." ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of 6 physical therapy visits. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is documentation of functional deficits. The patient may benefit from a course of physical therapy. However, the requested number of sessions exceeds guidelines for an initial trial. As such, the currently requested physical therapy 2x4 is not medically necessary.

CONSULT PSYCH: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 100-102. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain, Behavioral Interventions.

Decision rationale: Regarding the request for consult Psych, Chronic Pain Medical Treatment Guidelines state that psychological evaluations are recommended. Psychological evaluations are generally accepted, well-established diagnostic procedures not only with selected using pain problems, but also with more widespread use in chronic pain populations. Diagnostic evaluations should distinguish between conditions that are pre-existing, aggravated by the current injury, or work related. Psychosocial evaluations should determine if further psychosocial interventions are indicated. ODG states the behavioral interventions are recommended. Within the documentation available for review, there is no indication as to what the requested Psych consult is intended to address. In the absence of clarity regarding this issue, the currently requested Consult Psych is not medically necessary.