

<b>Case Number:</b>	CM14-0091023		
<b>Date Assigned:</b>	07/25/2014	<b>Date of Injury:</b>	04/16/2014
<b>Decision Date:</b>	09/26/2014	<b>UR Denial Date:</b>	06/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/16/2014

### 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 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 injured worker is a 58 year old male who reported an injury to both upper extremities. The clinical note dated 05/16/14 indicates the injured worker having completed 6 physical therapy sessions to date. The injured worker had complaints of numbness in both hands, left greater than right. Grip strength deficits were also identified. The note indicates the pain and numbness were affecting the injured worker's sleep hygiene. The clinical note dated 07/03/14 indicates that no inciting injury took place. However, the injured worker reported repetitive motions on a production line. The note indicates the injured worker having completed 12 physical therapy visits to date. The injured worker stated the pain was continuing to affect his sleep hygiene. Upon exam, the injured worker demonstrated 35 degrees of cervical flexion, 25 degrees of extension, and 65 degrees of bilateral rotation. Pain was elicited in all directions. Mild swelling was identified in both hands. The note does indicate the injured worker having a positive Tinel's over the median nerve bilaterally. X-rays of the cervical spine completed on 06/08/14 revealed narrowing at the C5-6 level with spurring. The electrodiagnostic studies completed on 07/22/14 revealed no evidence of a right upper extremity median, ulnar, radian sensory or motor neuropathy. No evidence of radiculopathy was identified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Nerve conduction studies of right upper extremity:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 261. Decision based on Non-MTUS Citation Official disability guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

**Decision rationale:** The documentation indicates the injured worker having recently undergone electrodiagnostic studies of the upper extremities on 07/20/14. No information was submitted regarding any significant changes in the injured worker's symptomology. Additionally, no information was submitted regarding significant changes in the injured worker's pathology identified by clinical exam. Given these factors, the request is not indicated as medically necessary.

**Nerve Conduction Studies of left upper extremity:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 261. Decision based on Non-MTUS Citation Official disability guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

**Decision rationale:** The documentation indicates the injured worker having recently undergone electrodiagnostic studies of the upper extremities on 07/20/14. No information was submitted regarding any significant changes in the injured worker's symptomology. Additionally, no information was submitted regarding significant changes in the injured worker's pathology identified by clinical exam. Given these factors, the request is not indicated as medically necessary.

**Physical Therapy (unspecified):** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back Chapter, Physical Medicine.

**Decision rationale:** The documentation indicates the injured worker having completed 12 physical therapy sessions to date. Additional therapy would be indicated with confirmation of the injured worker's objective functional improvement through the initial course of treatment. No information was submitted regarding the injured worker's response to the previously rendered treatment. Additionally, no information was submitted regarding the frequency, duration, or length of the physical therapy request. Given these factors, the request is not indicated as medically necessary.