

<b>Case Number:</b>	CM14-0204863		
<b>Date Assigned:</b>	01/02/2015	<b>Date of Injury:</b>	11/21/2011
<b>Decision Date:</b>	02/19/2015	<b>UR Denial Date:</b>	11/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/08/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Montana

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### 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 has a date of injury of 11/21/11 when the hood of a car fell onto the back of her head neck and upper back. Since that injury she continues to have complaint of neck pain, low back pain, right hand numbness and tingling and left arm and hand numbness and tingling, left leg pain, headaches, dizziness, anxiety and depression, and weight gain. Medications include extra strength Tylenol and Tylenol with Codeine. Previous electrodiagnostic tests did show normal bilateral EMGs with NCV evidence for moderate median nerve neuropathy. Her current diagnoses are closed head injury without neurologic impairment, cervical strain/sprain, cervical degenerative disease, lumbar strain/sprain, lumbar degenerative disease, left shoulder impingement, carpal tunnel syndrome and weight gain status post gastric bypass surgery. The primary treating physician has requested consultation with orthopedic specialist for left shoulder arthroscopy, referral to internist for endoscopy, weight management and somatoform disorder, continued chiropractic therapy for functional improvement, electromyography (EMG) of the bilateral upper extremities, nerve conduction velocities (NCV) of the bilateral upper extremities pain management referral.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Consultation with Orthopedic Specialist for Left Shoulder Arthroscopy QTY: 1: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7, Independent Medical Examinations and Consultations, page 127

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 7, Independent Medical Examinations and Consultations, page 127

**Decision rationale:** The ACOEM guidelines note that the primary treating physician may refer to other specialists if a diagnosis is uncertain or extremely complex, and psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. In this case the utilization review of 11/19/14 did modify the request for consultation with orthopedic specialist for left shoulder arthroscopy to an approval for a one-time consultation with orthopedic specialist. Authorization for arthroscopic left shoulder surgery with then be dependent on the recommendations from the orthopedic consultation. The request for orthopedic specialty consultation for left shoulder arthroscopy is not medically necessary.

**Referral to Internist for Endoscopy, Weight Management, Somatoform Disorder QTY: 1:**  
Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7, Independent Medical Examinations and Consultations, page 127

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 7, Independent Medical Examinations and Consultations, page 127.

**Decision rationale:** The ACOEM guidelines note that the primary treating physician may refer to other specialists if a diagnosis is uncertain or extremely complex, and psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. In this case the medical records do not clearly document an indication for endoscopy or a diagnosis of somatoform disorder. The request for referral to an internist for endoscopy, weight management and somatoform disorder is not medically indicated. Therefore, this request is not medically necessary.

**Continue Chiropractic Therapy for Functional Improvement QTY: 4 (Sessions):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation Page(s): 58-60.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation Page(s): 58-59.

**Decision rationale:** The MTUS notes that manual therapy & manipulation are recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. Treatment beyond 4-6 visits should be documented with objective improvement in function. Several studies of manipulation have looked at duration of treatment, and they generally showed measured improvement within the first few weeks or 3-6 visits of chiropractic treatment, although improvement tapered off after the initial sessions. If chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 visits. In this case, the injured worker has had chiropractic treatment. The medical records do not document any specific functional improvement related to those visits. The request for continued chiropractic therapy for functional improvement is not medically necessary.

**Electromyography (EMG) of the Bilateral Upper Extremities QTY: 4: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178 and 182. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Procedure Index, Electromyography.

**Decision rationale:** The MTUS states that electromyography (EMG) is recommended to clarify nerve root dysfunction in cases of suspected disc herniation preoperatively or before epidural injection. The Official Disability Guidelines state that while cervical electrodiagnostic studies are not necessary to demonstrate a cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality or some problem other than a cervical radiculopathy, but these studies can result in unnecessary over treatment. Electrodiagnostic studies should be performed by appropriately trained Physical Medicine and Rehabilitation or Neurology physicians. Dissociation of NCS and EMG results into separate reports is inappropriate unless specifically explained by the physician. Performance and/or interpretation of NCSs separately from that of the needle EMG component of the test should clearly be the exception (e.g. when testing an acute nerve injury) rather than an established practice pattern for a given practitioner. In this case electrodiagnostic testing was performed on 9/26/13. The Utilization review dated 11/19/14 did modify the request for separate EMG and NCV studies with approval of two (2) EMG/NCV studies of the upper extremities. As such, the request for a separate EMG of the bilateral upper extremities is not medically necessary.

**Nerve Conduction Velocity (NCV) of the Bilateral Upper Extremities QTY: 4: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Procedure Index, Nerve conduction studies

**Decision rationale:** The MTUS states that electromyography (EMG) and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than 3 or 4 weeks. The Official Disability Guidelines states that nerve conduction studies (NCS, used interchangeably with nerve conduction velocities (NCV)) are not recommended to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but recommended if the EMG is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely based on the clinical exam. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy. Electrodiagnostic studies should be performed by appropriately trained Physical Medicine and Rehabilitation or Neurology physicians. Dissociation of NCS and EMG results into separate reports is inappropriate unless specifically explained by the physician. Performance and/or interpretation of NCSs separately from that of the needle EMG component of the test should clearly be the exception (e.g. when testing an acute nerve injury) rather than an established practice pattern for a given practitioner. In this case, electrodiagnostic testing was performed on 9/26/13. The Utilization review dated 11/19/14 did modify the request for separate EMG and NCV studies with approval of two (2) EMG/NCV studies of the upper extremities. As such, the request for a separate NCV of the bilateral upper extremities is not medically necessary.