

<b>Case Number:</b>	CM14-0209154		
<b>Date Assigned:</b>	12/22/2014	<b>Date of Injury:</b>	06/14/2011
<b>Decision Date:</b>	02/13/2015	<b>UR Denial Date:</b>	12/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/15/2014

### **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 Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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 42-year-old woman who sustained a work-related injury on June 14, 2011. Subsequently, she developed chronic neck, low back, and hand pain. Prior treatments included: over-the-counter medications, prescribed medications, brace support, acupuncture, gentle exercise, stretching, use of ointment/patches, and massage. According to a medical evaluation report dated November 11, 2014, the patient reported bilateral shoulder pain, neck pain, low back pain, bilateral leg pain, and bilateral hand pain. Emotionally, the patient reported irritability, sleep difficulties, low energy, and sadness. The patient stated that she occasionally takes medication for pain and that she would like to go ahead with the neck surgery; however, the neck surgery has not been authorized. Although the patient reported that her right wrist was slightly better since having the right carpal tunnel release surgery, she still has numbness in 3 out of 5 fingers. Previously, all 5 fingers were numb. She elected not to go forward with the left carpal tunnel surgery because she didn't have much improvement on the right side. Upon examination, right and left elbow revealed tenderness to palpation at the ECRB and pain with resisted wrist extension. Positive Tinel's over the lateral epicondyle and flexion test were noted. Positive Durkan's test was noted on the right hand. Positive Tinel's, Phalen's, and Durkan's tests were noted on the left hand. The patient was diagnosed with bilateral carpal tunnel syndrome and bilateral lateral epicondylitis. The provider request authorization for occupational therapy, EMG/NCV for bilateral upper extremities, and follow-up visit.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

## **Occupational Therapy 8 Visits (2x4): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98,99. Decision based on Non-MTUS Citation Official Disability Guidelines- Treatment in Workers' Compensation- Elbow Procedure -Physical Therapy

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

**Decision rationale:** According to MTUS guidelines, Physical Medicine is recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007). There is no documentation of objective findings that the patient condition needed physical therapy. The patient underwent several physical therapy sessions without documentation of clear benefit. Therefore, occupational Therapy 8 visits is not medically necessary.

## **Electromyography (EMG), (BUE) Bilateral Upper Extremity: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 269.

**Decision rationale:** According to MTUS guidelines (MTUS page 303 from ACOEM guidelines), Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four

weeks. EMG has excellent ability to identify abnormalities related to disc protrusion (MTUS page 304 from ACOEM guidelines). According to MTUS guidelines, needle EMG study helps identify subtle neurological focal dysfunction in patients with neck and arm symptoms. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study 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 three or four weeks (page 178). EMG is indicated to clarify nerve dysfunction in case of suspected disc herniation (page 182). EMG is useful to identify physiological insult and anatomical defect in case of neck pain (page 179). There is no documentation of peripheral nerve damage, cervical radiculopathy and entrapment neuropathy that requires electrodiagnostic testing. There is no documentation of significant change in the patient condition. Therefore, the request for EMG/NCS BUE is not medically necessary.

**Follow Up Visit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 171, Chronic Pain Treatment Guidelines Chronic pain programs, early intervention Page(s): 32-33.

**Decision rationale:** According to MTUS guidelines, the presence of red flags may indicate the need for specialty consultation. In addition, the requesting physician should provide a documentation supporting the medical necessity for a surgery evaluation with a specialist. The documentation should include the reasons, the specific goals and end point for using the expertise of a specialist. In the chronic pain programs, early intervention section of MTUS guidelines stated: Recommendations for identification of patients that may benefit from early intervention via a multidisciplinary approach :( a) the patient's response to treatment falls outside of the established norms for their specific diagnosis without a physical explanation to explain symptom severity. (b) The patient exhibits excessive pain behavior and/or complaints compared to that expected from the diagnosis. (c) There is a previous medical history of delayed recovery. (d) The patient is not a candidate where surgery or other treatments would clearly be warranted. (e) Inadequate employer support. (f) Loss of employment for greater than 4 weeks. The most discernible indication of at risk status is lost time from work of 4 to 6 weeks. (Mayer 2003). The provider reported did not document lack of pain and functional improvement that require referral a follow up visit. The requesting physician did not provide a documentation supporting the medical necessity for a follow up evaluation. The documentation did not include the reasons, the specific goals and end point for using the expertise of a specialist for the patient pain. Therefore the request for Follow up visit is not medically necessary.