

<b>Case Number:</b>	CM15-0103104		
<b>Date Assigned:</b>	06/05/2015	<b>Date of Injury:</b>	09/26/2004
<b>Decision Date:</b>	07/07/2015	<b>UR Denial Date:</b>	05/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/29/2015

### 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: North Carolina

Certification(s)/Specialty: Family Practice

### 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 28 year old male with a September 26, 2004 date of injury. A progress note dated March 25, 2015 documents subjective findings (left shoulder pain with weakness and numbness; upper extremity pain; left shoulder trapezius and scapular pain and spasm; right shoulder pain secondary to over compensation for left shoulder and upper extremity pain; left wrist pain, numbness and tingling in the medical hand and last two fingers; neck pain; pain rated at a level of 5/10), objective findings (mild tenderness over the left sided lower cervical paraspinal region; moderate tenderness over the left trapezius and levator scapular region with tightness; left shoulder higher than the right; examination of the left shoulder limited by tightness and pain; decreased range of motion of the left shoulder; tenderness to palpation over the biceps tendon; mild protrusion of the left shoulder; may be slight swelling over the left hand compared to the right; skin hypersensitivity to light touch and light pressure over the left sided upper shoulder girdle region), and current diagnoses (chronic regional pain syndrome; myofascial pain and spasm; history of mild C4-5 spondylosis and right C5-6 degenerative disc disease; right shoulder pain with strain and acromioclavicular joint arthritis secondary to overuse, rule out potential rotator cuff syndrome; left ulnar aspect wrist and hand pain with numbness and tingling, cannot rule out ulnar neuropathy). Treatments to date have included acupuncture trial (two days of relief), medications, physical therapy (no relief), and transcutaneous electrical nerve stimulator unit (no relief). The medical record indicates that the injured worker is unable to tolerate many medications. The treating physician documented a plan of care that included electromyogram/nerve conduction velocity studies of the bilateral upper extremities and a physical therapy evaluation.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Outpatient electromyograph (EMG) and nerve conduction velocity (NCV) of the bilateral upper extremities:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173-174.

**Decision rationale:** The ACOEM chapter on neck and upper back complaints and special diagnostic studies states: Criteria for ordering imaging studies are: Emergence of a red flag. Physiologic evidence of tissue insult or neurologic dysfunction. Failure to progress in a strengthening program intended to avoid surgery. Clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electro diagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. 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. The assessment may include sensory-evoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected. If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps, including the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computed tomography [CT] for bony structures). Additional studies may be considered to further define problem areas. The recent evidence indicates cervical disk annular tears may be missed on MRIs. The clinical significance of such a finding is unclear, as it may not correlate temporally or anatomically with symptoms. The provided documentation does not show any signs of emergence of red flags or subtle physiologic evidence of tissue insult or neurologic dysfunction. There is no mention of planned invasive procedures. There are no subtle neurologic findings listed on the physical exam. For these reasons criteria for special diagnostic testing has not been met per the ACOEM. Therefore, the request is not medically necessary.

**Physical therapy evaluation:** 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 physical medicine Page(s): 98-99.

**Decision rationale:** The California chronic pain medical treatment guidelines section on physical medicine states: 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) Physical Medicine Guidelines Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks. Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2): 8-10 visits over 4 weeks. Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. The requested amount of physical therapy is in excess of California chronic pain medical treatment guidelines. The patient has already completed a course of physical therapy that was reported to be not helpful. Further physical therapy evaluation is not medically warranted. Therefore, the requested medical treatment is not medically necessary.