

<b>Case Number:</b>	CM15-0104520		
<b>Date Assigned:</b>	06/08/2015	<b>Date of Injury:</b>	08/23/2012
<b>Decision Date:</b>	07/09/2015	<b>UR Denial Date:</b>	05/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/01/2015

### 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: California, Indiana, New York  
Certification(s)/Specialty: Internal 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 is a 49 year old female, who sustained an industrial injury on 8/23/12. The injured worker has complaints of pain in her neck. The documentation noted that the pain radiates up into the back of her head causing her headaches with radiating pain to bilateral shoulders. The injured worker complains of right and left wrist pain that radiates into her fingers with swelling and numbness and tingling. The documentation noted that examination of the cervical spine reveals 3+ tenderness over the paraspinal muscles, trapezius and parascapular muscles, bilaterally and 3+ tenderness to palpation felt over the cervical spine process from C4 through C7. The diagnoses have included cervical spine sprain/strain with radiculitis, rule out herniated disc; lumbar spine sprain/strain with radiculitis, rule out herniated disc and bilateral wrists/hands sprain/strain, rule out bilateral carpal tunnel syndrome. Treatment to date has included baclofen and acetaminophen. The request was for physical therapy two times three and electromyography/nerve conduction velocity study of the bilateral upper/lower extremities (neck, back and right ankle).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy 2x3:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chronic Pain Treatment Guidelines Physical Medicine.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Physical therapy.

**Decision rationale:** Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, physical therapy two times per week times three weeks is not medically necessary. Patients should be formally assessed after a six visit clinical trial to see if the patient is moving in a positive direction, no direction or negative direction (prior to continuing with physical therapy). When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted. In this case, the injured worker's working diagnoses are cervical spine disc bulge; lumbar spine disc bulge; lumbar spine radiculitis. The documentation in the utilization review indicates the injured worker was previously approved for six physical therapy sessions on March 18, 2015. The authorization remains valid. There is no clinical indication or rationale for a duplication of physical therapy services previously authorized. Based on the clinical information in the medical record, the peer-reviewed evidence-based guidelines and the prior authorization that remains valid through the present for six physical therapy sessions, physical therapy two times per week times three weeks is not medically necessary.

**EMG (electromyography)/NCV (nerve conduction velocity) of the bilateral upper/lower extremities (neck, back & right ankle):** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), electrodiagnostic testing.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck section and low back section; EMG/NCV.

**Decision rationale:** Pursuant to the Official Disability Guidelines, EMG/NCV studies of the bilateral upper extremities and the bilateral lower extremities, neck, back and right ankle are not medically necessary. Nerve conduction studies are not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. EMGs may be useful to obtain unequivocal evidence of radiculopathy, after one month conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious. The ACOEM states unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging if symptoms persist. The ACOEM states (chapter 8 page 178) unequivocal findings that identifies specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging 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. Nerve conduction studies 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-neuropathies if other diagnoses may be likely based on physical examination. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy. While cervical electro diagnostic studies are not necessary to demonstrate his cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality, diabetic neuropathy or some problem other than cervical radiculopathy. In this case, the injured worker's working diagnoses are cervical spine disc bulge; lumbar spine disc bulge; lumbar spine radiculitis. The utilization review indicates there is no focal neurologic deficit in the cervical or lumbar region/nerve. According to a March 12, 2015 progress note, subjectively the injured worker has pain in the neck, low back, bilateral shoulders, bilateral elbows and bilateral wrist. The injured worker has subjective radicular pain down both legs. Objectively, the cervical spine is tentative palpation over the bilateral paraspinal muscle groups. There is no objective evidence of cervical radiculopathy. There is a positive impingement test bilaterally at the shoulders. Lumbar spine is tenderness to palpation over the paraspinal muscle groups. Straight leg raising is positive at 70. There is no neurologic evaluation involving the lower extremities. There is no motor examination and there is no sensory examination. There is no objective evidence of lumbar radiculopathy. Consequently, absent clinical documentation of upper and lower extremity objective neurologic dysfunction on physical examination, unequivocal findings that identify specific nerve compromise and red flags, EMG/NCV studies of the bilateral upper extremities and the bilateral lower extremities, neck, back and right ankle are not medically necessary.