

Case Number:	CM15-0134227		
Date Assigned:	07/23/2015	Date of Injury:	11/20/2013
Decision Date:	09/18/2015	UR Denial Date:	06/15/2015
Priority:	Standard	Application Received:	07/10/2015

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: Indiana

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 is a 56-year-old female, who sustained an industrial injury on 11/20/2013, while employed as a housekeeper. She reported pain in her neck, shoulders, and upper back, while pulling a bag of linens. The injured worker was diagnosed as having displacement of cervical intervertebral disc without myelopathy. Treatment to date has included diagnostics, physical therapy, and medications. Per the Qualified Medical Evaluation (11/07/2014), the injured worker complained of aching in the shoulder blades and shoulders. Pain was more bothersome in the left shoulder, where she had a previous surgery, and she felt that symptoms were getting worse in both shoulders. In this report, medical records with recommendations were referenced, including Electromyogram and nerve conduction studies. No diagnostics were submitted. A current progress report, with subjective complaints or objective findings, was not submitted. The current treatment plan included Electromyogram and nerve conduction studies of the upper and lower extremities and trial massage therapy for the neck and upper back, 2x4.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG of the bilateral upper extremities: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260-262. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Electrodiagnostic testing (EMG/NCS).

Decision rationale: ACOEM States "Appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful." ODG states "Recommended needle EMG or NCS, depending on indications. Surface EMG is not recommended. Electromyography (EMG) and Nerve Conduction Studies (NCS) are generally accepted, well-established and widely used for localizing the source of the neurological symptoms and establishing the diagnosis of focal nerve entrapments, such as carpal tunnel syndrome or radiculopathy, which may contribute to or coexist with CRPS II (causalgia), when testing is performed by appropriately trained neurologists or physical medicine and rehabilitation physicians (improperly performed testing by other providers often gives inconclusive results). As CRPS II occurs after partial injury to a nerve, the diagnosis of the initial nerve injury can be made by electrodiagnostic studies". ODG further clarifies "NCS is not recommended, but EMG is recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious." The treating physician notes that the patient has had a previous EMG of an unknown body part but does not document the results of that EMG and the medical reason a new EMG is needed. As such, the request for EMG of the bilateral upper extremities is not medically necessary.

NCV of the bilateral upper extremities: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260-262. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Electrodiagnostic testing (EMG/NCS).

Decision rationale: ACOEM States "Appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful." ODG states "Recommended needle EMG or NCS, depending on indications. Surface EMG is not recommended. Electromyography (EMG) and Nerve Conduction Studies (NCS) are generally accepted, well-established and widely used for localizing the source of the neurological symptoms and establishing the diagnosis of focal nerve entrapments, such as carpal tunnel syndrome or radiculopathy, which may contribute to or coexist with CRPS II (causalgia), when testing is performed by appropriately trained neurologists or physical medicine and rehabilitation physicians (improperly performed testing by other providers often gives inconclusive results). As CRPS II occurs after partial injury to a nerve, the diagnosis of the initial nerve injury can be made by electrodiagnostic studies". ODG further clarifies "NCS is not recommended, but EMG is recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious." The treating physician notes that the patient has had a previous NCV of an unknown body part but does not document the results of

that NCV and the medical reason a new NCV is needed. As such, the request for NCV of the bilateral upper extremities is not medically necessary.

EMG of the bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Electrodiagnostic testing (EMG/NCS).

Decision rationale: ACOEM states "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." ODG states in the Low Back Chapter and Neck Chapter, "NCS is not recommended, but EMG is recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. Electrodiagnostic studies should be performed by appropriately trained Physical Medicine and Rehabilitation or Neurology physicians. See also Monofilament testing". The treating physician notes that the patient has had a previous EMG of an unknown body part, and does not document the results of that EMG. In addition, the treating physician does not document lumbar radiculopathy, and the medical reason a new EMG is needed at this time. As such, the request for EMG of the bilateral lower extremities is not medically necessary.

NCV of the bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Electrodiagnostic testing (EMG/NCS).

Decision rationale: ACOEM states "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." ODG states in the Low Back Chapter and Neck Chapter, "NCS is not recommended, but EMG is recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. Electrodiagnostic studies should be performed by appropriately trained Physical Medicine and Rehabilitation or Neurology physicians. See also Monofilament testing". The treating physician notes that the patient has had a previous NCV of an unknown body part, and does not document the results of that NCV. In addition, the treating physician does not document lumbar radiculopathy, and the medical reason a new NCV is needed at this time. As such, the request for NCV of the bilateral lower extremities is not medically necessary.

Message therapy for the neck and upper back (2 times per week for 4 weeks): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage therapy Page(s): 60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Massage Therapy, Manual Therapy.

Decision rationale: MTUS states regarding massage therapy, "Recommended as an option as indicated below. This treatment should be an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4-6 visits in most cases." ODG offers additional frequency and timeline for massage therapy by recommending: a. Time to produce effect: 4 to 6 treatments. b. Frequency: 1 to 2 times per week for the first 2 weeks as indicated by the severity of the condition. Treatment may continue at 1 treatment per week for the next 6 weeks. c. Maximum duration: 8 weeks. At week 8, patients should be reevaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain and improving quality of life. The request is in excess of the guidelines recommendation of 4-6 visits over no more than 8 weeks. Medical documents do not indicate reasons for treatment in excess of the 8-week maximum without. As such, the request for massage therapy is not medically necessary at this time