MAXIMUS Federal Services

| Case Number: | CM15-0191194 | | |
|---|---|---|---|
| Date Assigned: | 10/05/2015 | Date of Injury: | 06/18/2015 |
| Decision Date: | 12/04/2015 | UR Denial Date: | 09/22/2015 |
| Priority: | Standard | Application Received: | 09/29/2015 |

## 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: California
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 54 year old female, who sustained an industrial injury on 06-18-2015. The injured worker is currently on modified duty. Medical records indicated that the injured worker is undergoing treatment for thoracic sprain-strain, cervical sprain-strain, left elbow sprain-strain, contusion to shoulder region, and lumbar sprain-strain. Treatment and diagnostics to date has included 6 physical therapy sessions (from 07-09-2015 through 08-19-2015), acupuncture, and left elbow MRI. After review of progress notes dated 07-23-2015 and 07-30-2015, the injured worker reported thoracic and lumbar pain, left elbow pain, neck pain, and left shoulder pain. The treating physician noted that the injured worker is "responding well to physical therapy". Objective findings included no tenderness to left shoulder or posterior cervical area, unrestricted neck range of motion, and tenderness to lateral epicondyle. The Utilization Review with a decision date of 09-22-2015 denied the request for electromyography-nerve conduction velocity studies to bilateral lower extremities and bilateral upper extremities, physical therapy to cervical spine, lumbar spine, left shoulder, and left elbow x 12 visits, and acupuncture x 6 visits.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Electromyograph (EMG) and nerve conduction velocity (NCV) of bilateral lower extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), EMGs (electromyography).

**Decision rationale:** According to the Official Disability Guidelines, EMG's are recommended as an option and may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy. The patient has had previous diagnostic studies including x-ray and MRI, which were not positive for any nerve compromise. There is no presumptive diagnosis of peripheral nerve compression and there is no clear documentation of how this test result will change the treatment plan. Detailed evidence of severe and/or progressive neurological abnormalities has not been documented. Electromyograph (EMG) and nerve conduction velocity (NCV) of bilateral lower extremities is not medically necessary.

**Electromyograph (EMG) and nerve conduction velocity (NCV) of bilateral upper extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic), Electromyography (EMG).

**Decision rationale:** According to the Official Disability Guidelines, EMG's are recommended as an option and may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy. The patient has had previous diagnostic studies including x-ray and MRI which were not positive for any nerve compromise. There is no presumptive diagnosis of peripheral nerve compression and there is no clear documentation of how this test result will change the treatment plan. Detailed evidence of severe and/or progressive neurological abnormalities has not been documented. Electromyograph (EMG) and nerve conduction velocity (NCV) of bilateral upper extremities is not medically necessary.

**12 physical therapy visits to the cervical spine, lumbar spine, left shoulder and left elbow:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines state that 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. Therapeutic physical therapy for the low back is recommended by the MTUS as an option with authorization for a trial of 6 visits over 2 weeks, with evidence of objective functional improvement prior to authorizing more treatments. The records show evidence of objective functional improvement and the patient has not exceeded the number of sessions allotted by the MTUS Guidelines. I am reversing the previous utilization review decision. 12 physical therapy visits to the cervical spine, lumbar spine, left shoulder and left elbow are medically necessary.

**6 acupuncture visits:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment 2007.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment 2007.

**Decision rationale:** The Acupuncture Medical Treatment Guidelines state that the initial authorization for acupuncture is for 3-6 treatments. Authorization for more than 6 treatments would be predicated upon documentation of functional improvement. The records show evidence of objective functional improvement and the patient has not exceeded the number of sessions allotted by the MTUS Guidelines. I am reversing the previous utilization review decision. 6 acupuncture visits are medically necessary.