MAXIMUS Federal Services

| Case Number: | CM15-0020085 | | |
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| Date Assigned: | 02/09/2015 | Date of Injury: | 12/02/2010 |
| Decision Date: | 04/01/2015 | UR Denial Date: | 01/30/2015 |
| Priority: | Standard | Application Received: | 02/03/2015 |

## 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: Physical Medicine & Rehabilitation

## 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 57 year old female, who sustained an industrial injury on 12/02/2010. The mechanism of injury was not noted. The diagnoses have included sprain of neck, sprain of thoracic, sprains and strains of unspecified site of shoulder and upper arm, sprain of wrist, unspecified site, and sprains and strains of unspecified site of knee and leg. Treatment to date has included conservative measures. Currently, the injured worker complains of pain to the neck, upper back, left shoulder, right wrist and hand, and right knee. The pain was not described and no new numbness or tingling was described. She also reported continued left knee pain. Light touch sensation was intact to the left lower extremity. Exam of the upper extremities was not documented. The PR2 report, dated 1/14/2015, documented findings from recent cervical and thoracic spine magnetic resonance imaging reports. Current medications were not documented. Treatment plan included electromyelogram studies of the upper extremities, shockwave for the right knee, non-steroidal anti-inflammatories (not specified), and physical therapy (not specified). On 1/30/2015, Utilization Review non-certified a request for electromyelogram studies of the upper extremities, citing ACOEM Guidelines, non-certified a request for shockwave therapy right knee, citing Official Disability Guidelines, non-certified a request for pain medications (non-steroidal anti-inflammatory) unspecified, citing Official Disability Guidelines, and non-certified a request for physical therapy (unspecified frequency and duration), noting the lack of compliance with MTUS Chronic Pain Medical Treatment Guidelines.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**EMG, upper extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 262. Decision based on Non-MTUS Citation Official disability guidelines Pain Chapter on EMG/NCS.

**Decision rationale:** This patient presents with left knee, neck, upper back, left shoulder, right wrist/hand, and right knee pain. The treater is requesting EMG, UPPER EXTREMITIES. The RFA dated 01/14/2015 shows, "per instructions under requested treatment above we are indicating the following page labeled requested treatment of the attached medical report on which the requested treatment can be found. See requested treatment. The patient's date of injury is from 12/02/2010 and she is currently off work. The ACOEM guidelines page 262 on EMG/NCV states that appropriate studies EDS may help differentiate between CTS and other condition such as cervical radiculopathy. In addition, ODG states that electrodiagnostic testing includes testing for nerve conduction velocities and possibly the addition of electromyography EMG. Electromyography and nerve conduction velocities including H-reflex test may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms or both, lasting more than 3 or 4 weeks. The records do not show any previous EMG of the upper extremities. The 01/14/2015 report shows left mid anterior thigh, left mid lateral calf, left lateral ankle sensations are intact to light touch. No other physical examination was noted on this report. In this case, the patient does not present with any radiating symptoms to the upper extremities including neurological or sensory deficits that would warrant the need for an EMG. The request IS NOT medically necessary.

**Shockwave therapy for the right knee:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- Knee & Leg.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Knee and leg chapter on Extracorporeal Shockwave Therapy.

**Decision rationale:** This patient presents with left knee, neck, upper back, left shoulder, right wrist/hand, and right knee pain. The treater is requesting SHOCKWAVE THERAPY FOR THE RIGHT KNEE. The RFA dated 01/14/2015 shows, "per instructions under requested treatment above we are indicating the following page labeled requested treatment of the attached medical report on which the requested treatment can be found. See requested treatment. The patient's date of injury is from 12/02/2010 and she is currently off work. The MTUS and ACOEM Guidelines do not address this request. However, the ODG Guidelines under the knee chapter on

Extracorporeal Shockwave Therapy states, "Under study for patellar tendinopathy and for long-bone hypertrophic non-unions." Meeting suggest that extracorporeal shockwave therapy (ESWT) is ineffective for treating patellar tendinopathy, compared to the current standard of care emphasizing multimodal physical therapy focused on muscle retraining, joint mobilization, and patellar taping. The records do not show any previous shockwave therapy to the right knee. The 01/14/2015 report does not show an examination of the patient's right knee. In this case, the ODG guidelines currently do not recommend shockwave therapy for patellar tendinopathy and long-bone hypertrophic non-unions. The request IS NOT medically necessary.

**Pain Meds:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- Pain.

**MAXIMUS guideline:** Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines Anti-inflammatory medication, Medications for chronic pain Page(s): 22, 60.

**Decision rationale:** This patient presents with left knee, neck, upper back, left shoulder, right wrist/hand, and right knee pain. The treater is requesting PAIN MEDS. The RFA dated 01/14/2015 shows, "per instructions under requested treatment above we are indicating the following page labeled requested treatment of the attached medical report on which the requested treatment can be found. See requested treatment." The patient's date of injury is from 12/02/2010 and she is currently off work. The MTUS Guidelines page 22 on anti-inflammatory medication states that anti-inflammatories are the traditional first-line treatment to reduce pain so activity and functional restoration can resume, but long term use may not be warranted. MTUS page 60 on medications for chronic pain states that pain assessment and functional changes must also be noted when medications are used for chronic pain. The 01/14/2015 report notes that the patient is currently on NSAIDs. There is no discussion as to what specific pain meds the treater is requesting, its dosage, and the quantity requested. The reports do not show medication efficacy as it relates to the use of the patient's current medication regimen. In this case, the requested unknown pain meds with an unknown number of quantity and duration is not supported by the guidelines. The request IS NOT medically necessary.

**Physical Therapy; unspecified frequency and duration:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99.

**Decision rationale:** This patient presents with left knee, neck, upper back, left shoulder, right wrist/hand, and right knee pain. The treater is requesting PHYSICAL THERAPY UNSPECIFIED FREQUENCY AND DURATION. The RFA dated 01/14/2015 shows, "per instructions under requested treatment above we are indicating the following page labeled requested treatment of the attached medical report on which the requested treatment can be

found. See requested treatment." The patient’s date of injury is from 12/02/2010 and she is currently off work. The MTUS Guidelines page 98 and 99 on physical medicine recommends 8 to 10 visits for myalgia, myositis, and neuralgia type symptoms. The patient is not post-surgery. The records do not show any previous physical therapy reports. None of the reports from 12/11/2014 to 01/14/2015 discuss physical therapy. In this case while the patient can benefit from a short course of physical therapy, the current request for an unspecified number of physical therapy with an unknown duration is not supported by the guidelines. The request IS NOT medically necessary.