

Case Number:	CM15-0212882		
Date Assigned:	11/02/2015	Date of Injury:	04/23/2014
Decision Date:	12/21/2015	UR Denial Date:	09/30/2015
Priority:	Standard	Application Received:	10/29/2015

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: Texas, California
 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:

The injured worker is a 34 year old male, who sustained an industrial injury on 04-23-2014. A review of the medical records indicates that the worker is undergoing treatment for cervical and thoracic sprain and strain, cervical radiculitis, thoracic myospasms and headaches. Treatment has included pain medication, physical therapy and occupational therapy. MRI of the cervical spine on 02-17-2015 showed cervical muscular spasm and 3 mm broad-based posterior C5-C6 disc herniation. A doctor's first report of illness or injury dated 01-30-2015 noted that the worker had one physical therapy session after the injury without benefit. The worker reported a tension sensation in the neck with constant pressure sensation in the back and left shoulder blade associated with headaches and radiating pain to the left hand. Objective findings showed decreased cervical and dorsal spine range of motion with guarding and paravertebral tenderness. The worker was noted to be undergoing occupational therapy at that time. A physician progress note dated 03-27-2015 shows that the worker was reporting facial numbness on the right and an eye twitch and that physical therapy would be discontinued with no change in symptoms with physical therapy. Subjective complaints (08-30-2015 and 09-25-2015) included back pain rated as 2-7 out of 10, neck pain rated as 2-6 out of 10 and headaches rated as 2-8 out of 10. Objective findings (08-30-2015 and 09-25-2015) included 2+ tenderness to palpation of the cervical musculature, decreased range of motion, increased cervical pain with Soto-Hall, shoulder depression and FCT and 2+ tenderness in the thoracic musculature. The physician noted that the worker was just starting physical therapy and had seen the orthopedist who wanted to do an EMG-NCV. The physician noted that EMG-NCV of the upper extremities and physical therapy

2x4 was being requested. There was no documentation as to how many physical therapy visits had been received and to which body part (s) therapy was applied. There was no specification as to which body parts physical therapy was being requested to treat. There is no documentation of significant pain relief or objective functional improvement with prior physical therapy. The patient sustained the injury when he was pumping a sprayer. The medication list include Ibuprofen, naprosyn, Cyclobenzaprine, Norco, Pantoprazole and Ultram and Valium. Per the QME note dated 10/8/15 the patient had complaints of pain left upper back with neck stiffness and tingling in left hand. Physical examination of the cervical spine revealed tenderness on palpation, full ROM, negative Spurling test and normal sensory and motor examination. The patient had X-ray thoracic spine that was normal.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy for cervical and thoracic 2 x 4: Upheld

Claims Administrator guideline: Decision based on MTUS General Approaches 2004, Section(s): General Approach to Initial Assessment and Documentation, and Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: The guidelines cited below state, allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home physical medicine. The patient has received an unspecified number of PT visits for this injury. The requested additional visits in addition to the previously certified PT sessions are more than recommended by the cited criteria. There was no evidence of ongoing significant progressive functional improvement from the previous PT visits that is documented in the records provided. Per the guidelines cited, Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels." A valid rationale as to why remaining rehabilitation cannot be accomplished in the context of an independent exercise program is not specified in the records provided. The request for Physical therapy for cervical and thoracic 2 x 4 is not medically necessary.

EMG/NCV bilateral upper extremities: Overturned

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

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies.

Decision rationale: Per ACOEM chapter 12 guidelines, 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. Per the ACOEM guidelines cited below,

for most patients presenting with true neck or upper back problems, special studies are not needed unless a three-or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out. 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 patient had diagnoses of cervical and thoracic sprain and strain, cervical radiculitis, thoracic myospasms and headaches. MRI of the cervical spine on 02-17-2015 showed cervical muscular spasm and 3 mm broad-based posterior C5-C6 disc herniation. The worker reported a tension sensation in the neck with headaches and radiating pain to the left hand. Objective findings (08-30-2015 and 09-25-2015) included 2+ tenderness to palpation of the cervical musculature, decreased range of motion, increased cervical pain with Soto-Hall. Per the QME note dated 10/8/15 the patient had complaints of pain left upper back with neck stiffness and tingling in the left hand. The patient could have peripheral neuropathy or cervical radiculopathy. It is necessary to do electro-diagnostic studies to find out the exact cause of the symptoms in the upper extremities. Electrodiagnostic studies would help to clarify the exact cause of the neurological symptoms and also would help to identify the level at which nerve root impingement may be occurring. This information would guide further management. The request for EMG/NCV bilateral upper extremities is medically necessary for this patient at this time.