

<b>Case Number:</b>	CM15-0035976		
<b>Date Assigned:</b>	03/04/2015	<b>Date of Injury:</b>	06/04/2010
<b>Decision Date:</b>	04/16/2015	<b>UR Denial Date:</b>	01/30/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/25/2015

### 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, Hawaii  
 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 39 year old male, who sustained an industrial injury on June 4, 2010. The diagnoses have included shoulder impingement. Treatment to date has included left shoulder surgery, physical therapy, and medication. Currently, the injured worker complains of left shoulder symptoms. The Treating Physician's report dated December 19, 2014, noted the injured worker status post left shoulder arthroscopy with subacromial decompression and rotator cuff debridement with improvement of range of motion (ROM) and pain. The injured worker was noted to be lacking full range of motion (ROM) with some weakness, with the Physician recommending physical therapy with the hope of transiting to a home exercise program (HEP). On January 30, 2015, Utilization Review non-certified a follow up evaluation with an orthopedic specialist (cervical), physical therapy 2 times per week times 4 (for neck, left shoulder/wrist), and electromyography (EMG)/nerve conduction velocity (NCV) of the bilateral upper extremities, noting the medical necessity for the request were not evident. The MTUS Chronic Pain Medical Treatment Guidelines, the MTUS American College of Occupational and Environmental Medicine (ACOEM) Guidelines, the MTUS Post-Surgical Medical Treatment Guidelines, and the Official Disability Guidelines (ODG) were cited. On February 25, 2015, the injured worker submitted an application for IMR for review of a follow up evaluation with an orthopedic specialist (cervical), physical therapy 2 times per week times 4 (for neck, left shoulder/wrist), and electromyography (EMG)/nerve conduction velocity (NCV) of the bilateral upper extremities.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Follow-up evaluation with an orthopedic specialist (cervical):** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Treatment for Workers' Compensation (ODG-TWC) Pain Procedure Summary last updated 01/19/2015.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, Chapter 7, Pg. 127.

**Decision rationale:** The patient presents with pain in the neck, left shoulder, and wrist with numbness and weakness. The current request is for follow-up evaluation with an orthopedic specialist (cervical). The treating physician requests via RFA on 1/21/15 (B18) "follow-up." ACOEM guidelines state that the occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A referral may be for consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. In this case, the clinical records provided were very limited. The patient is currently in the post-surgical treatment period as the patient is post left shoulder arthroscopy with subacromial decompression with debridement of the rotator cuff on 10/27/14. The current request is medically necessary and the recommendation is for authorization.

**Physical therapy 2 times per week times 4 ( for neck, left shoulder/wrist):** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

**Decision rationale:** The patient presents with left shoulder symptoms. The current request is for physical therapy (PT) 2 times per week times 4 (for neck, left shoulder/wrist). Patient is post-left shoulder arthroscopy with subacromial decompression with debridement of the rotator cuff (10/27/14). Patient was approved for 12 visits of PT. The treating physician states on 12/19/14 (D23) that the patient has been undergoing physical therapy which has provided improvement in his range of motion and pain but that "At this time I am going to recommend that the patient undergo an additional four weeks of physical therapy two times a week. He is progressing. He is lacking full range of motion as well as he does have some weakness. I do believe that he can improve with continued physical therapy." Post-Surgical MTUS Guidelines would appear to apply in this case as the time frame for treatment is 6 months. The recommendation for shoulder postsurgical treatment is 30 visits. In this case, the patient has completed 12 of the 30 recommended physical therapy sessions. The current request is for an additional 8 sessions of

PT. The patient has therefore not completed the full allotment of therapy sessions. The current request is medically necessary and the recommendation is for authorization.

**Electromyography (EMG)/Nerve conduction velocity (NCV) of the bilateral upper extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178. Decision based on Non-MTUS Citation ODG-TWC Neck & Upper Back Procedure summary last updated 11/18/2014.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 262.

**Decision rationale:** The patient presents with pain in the neck, left shoulder, and wrist with numbness and weakness. The current request is for electromyography (EMG)/Nerve conduction velocity (NCV) of the bilateral upper extremities. The treating physician states requests on 1/21/15 (B19) "Electrodiagnostics." Upon examination, there was diminished sensation of the left hand and weakness of the left shoulder and wrist. MTUS guidelines do not address EMG/NCV testing. ACOEM Guidelines page 262 recommends electrodiagnostic studies to help differentiate between CTS and other conditions, such as cervical radiculopathy. ODG states that an EMG is recommended as an option in selected cases. In this case, the clinical records provided do not document radiculopathy, carpal tunnel syndrome, double crush syndrome or the possibility of peripheral neuropathy, which would require electrodiagnostic studies to differentiate. The current request is not medically necessary and the recommendation is for denial.