

<b>Case Number:</b>	CM15-0082586		
<b>Date Assigned:</b>	05/05/2015	<b>Date of Injury:</b>	12/13/2014
<b>Decision Date:</b>	07/07/2015	<b>UR Denial Date:</b>	04/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/29/2015

### 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: New Jersey, Alabama, California  
 Certification(s)/Specialty: Neurology, Neuromuscular 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 43-year-old female, who sustained an industrial injury on 12/13/14. The injured worker has complaints of right shoulder pain; right elbow pain and right arm weakness. The diagnoses have included right shoulder impingement syndrome; right elbow medial and lateral epicondylitis; right ribcage pain and rule out right upper extremity radiculopathy. Treatment to date has included physical therapy; right elbow, right ribs and shoulder X-rays and physiotherapy. The request was for magnetic resonance imaging (MRI) of the cervical spine without dye; magnetic resonance imaging (MRI) of the right shoulder without dye; electromyography/nerve conduction study of the bilateral upper extremities and physical therapy, two times weekly for 6 weeks, 12 sessions.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI (magnetic resonance imaging) of the Cervical Spine without dye:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 165-194.

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

**Decision rationale:** According to MTUS guidelines, MRI of the cervical spine is recommended if there is clinical or neurophysiological evidence of disc herniation or an anatomical defect and if there is failure of therapy trials. There is no clinical evidence of anatomical defect or nerve compromise in this case. Therefore, the request for an MRI of cervical spine is not medically necessary.

**MRI (magnetic resonance imaging) of the Right Shoulder without dye:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 195-224.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209.

**Decision rationale:** According to MTUS guidelines, MRI of the shoulder is indicated in case of tumor, infection, ligament instability and rotator cuff injury. There is no clinical evidence or documentation of one of the above diagnosis. Therefore MRI of the right shoulder is not medically necessary.

**EMG (electromyography) Bilateral Upper Extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 165-194.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Special studies and diagnostic and treatment considerations Page(s): 178.

**Decision rationale:** According to MTUS guidelines (MTUS page 303 from ACOEM 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." EMG has excellent ability to identify abnormalities related to disc protrusion (MTUS page 304 from ACOEM guidelines). According to MTUS guidelines, needle EMG study helps identify subtle neurological focal dysfunction in patients with neck and arm symptoms. "When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study 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" (page 178). EMG is indicated to clarify nerve dysfunction in case of suspected disc herniation (page 182). EMG is useful to identify physiological insult and anatomical defect in case of neck pain (page 179). The patient developed chronic upper extremities pain without recent evidence of radicular pain and no recent clear justification for the need of an EMG. Therefore, the request for EMG of Bilateral Upper Extremities is not medically necessary.

**Physical Therapy, 2 times weekly for 6 weeks, 12 sessions:** Upheld

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

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

**Decision rationale:** According to MTUS guidelines, Physical Medicine is "recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. 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. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment." (Fritz, 2007). There is no documentation on the efficacy and outcome of previous physical therapy sessions. There is no documentation that the patient cannot perform home exercise. Therefore, the request for 12 physical therapy sessions is not medically necessary.