

Case Number:	CM14-0136710		
Date Assigned:	09/10/2014	Date of Injury:	01/10/2011
Decision Date:	10/07/2014	UR Denial Date:	08/12/2014
Priority:	Standard	Application Received:	08/25/2014

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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in Illinois. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This injured worker is a woman with a date of injury on January 10, 2011. She has chronic pain in her hand, wrist, and neck with radiation to her shoulders; and low back pain with radiation to her left leg. She also has numbness and tingling of both wrists and diffuse decrements in range of motion. She had been treated with medications, splinting, and physical therapy. She completed 14 sessions of physical therapy through August 2, 2012. Per the clinical note on July 3, 2012, she had diffuse musculoskeletal complaints, loss of sleep and psychological complaints. Her exam was remarkable for tenderness and restricted range of motion due to pain in all musculoskeletal areas of complaint. Off work orders were given through August 2012.

IMR ISSUES, DECISIONS AND RATIONALES

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

12-18 PHYSICAL THERAPY SESSIONS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE GUIDELINES.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Physical Medicine Treatment

Decision rationale: Per the Medical Treatment Utilization Schedule and Official Disability Guidelines, physical therapy is recommended. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the worker) can provide short term relief during the early phases of acute pain treatment or acute exacerbations of chronic pain 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). Workers 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. The Official Disability Guidelines allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home physical therapy. For myalgia and myositis, unspecified (ICD9 729.1), the criterion is 9-10 visits over 8 weeks, and for neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2), the criterion is 8-10 visits over 4 weeks. The worker has completed 14 sessions of physical therapy through August 2, 2012. However, there is no documentation of functional improvement, return to a full workload, decrease in medications, or better ease of performing activities of daily living. Additional physical therapy sessions are only authorized with evidence of improvement. Therefore, the request is not medically necessary.

1 LOWER EXTREMITY EMG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, NECK AND UPPER BACK (ACUTE AND CHRONIC)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-347.

Decision rationale: The injured worker has complaints of low back pain with radiation to her left leg; radiculopathy is already established. Per the Medical Treatment Utilization Schedule, electromyography and nerve conduction velocity studies for regional knee pain are not recommended. Therefore, the requested service is not considered medically necessary.

1 UPPER EXTREMITY NCV: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, NECK AND UPPER BACK (ACUTE AND CHRONIC)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 209,269 and 272.

Decision rationale: The injured worker has pain in her neck with radiation to her shoulders and numbness and tingling of both wrists, therefore radiculopathy is already established. She has also been treated for bilateral carpal tunnel syndrome and MTUS does not recommend electrodiagnostic studies for shoulder pain, therefore electrodiagnostic studies are not medically necessary.

1 FOLLOW VISIT WITH ORTHO SURGEON: Overturned

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 Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 253. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Hand and Wrist, Office Visits

Decision rationale: Per American College of Occupational and Environmental Medicine, primary care or occupational physicians can effectively manage acute and subacute problems conservatively in the absence of red flags. However, the Official Disability Guidelines support orthopedic follow-up visits when the worker is actively being treated. This worker was being treated for bilateral carpal tunnel syndrome, dequervain's tendonitis, and left lateral epicondylitis. Therefore, the request is medically necessary. The Official Disability Guidelines support orthopedic follow-up visits when the worker is actively being treated.

1 LOWER EXTREMITY NCV: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, NECK AND UPPER BACK (ACUTE AND CHRONIC)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 343.

Decision rationale: The injured worker has complaints of low back pain with radiation to her left leg; radiculopathy is already established. Per the American College of Occupational and Environmental Guidelines, electromyography and nerve conduction velocity studies for regional knee pain is not recommended. Therefore, the requested service is not considered medically necessary.

1 UPPER EXTREMITY EMG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, NECK AND UPPER BACK (ACUTE AND CHRONIC)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 269,272; 209.

Decision rationale: The injured worker has pain in her neck with radiation to her shoulders, as well as numbness and tingling of both wrists. As radiculopathy is already established there is no medical necessity for an upper extremity electromyogram. She has also been treated for bilateral carpal tunnel syndrome. The American College of Occupational and Environmental Medicine guidelines do not recommend electromyography for shoulder pain. Therefore, the upper extremity electromyogram is not considered medically necessary.