

Case Number:	CM15-0018208		
Date Assigned:	02/06/2015	Date of Injury:	09/17/2014
Decision Date:	03/25/2015	UR Denial Date:	12/31/2014
Priority:	Standard	Application Received:	01/30/2015

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: North Carolina
 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 September 17, 2014. He has reported injuries to his neck, left shoulder/arm, and left hand/fingers. The diagnoses have included neck sprain, rotator cuff tear, neuralgia/neuritis, and shoulder/arm sprain. Treatment to date has included x-rays, muscle relaxant and non-steroidal anti-inflammatory medications, and work modifications. The medical records include orders for acupuncture and physical therapy for the left shoulder but do not provide documentation of the services having been rendered. On December 11, 2014, the treating physician noted constant neck pain with radiation to the left trapezius and the entire left arm, with associated tingling. There was constant left shoulder pain. The physical exam revealed decreased range of motion of the cervical spine and left shoulder with guarding and tenderness of the paravertebral, trapezius, and lateral shoulder. There was mildly decreased strength due to pain. The treatment plan included electromyography/nerve conduction velocity of bilateral upper extremities and physical therapy. On January 30, 2015, the injured worker submitted an application for IMR for review of a request for EMG/NCV (electromyography/nerve conduction velocity) of the bilateral upper extremities and a prescription for 12 visits (3 x 4) of physical therapy. The electromyography/nerve conduction velocity was non-certified based on lack of documentation of a specific neurological deficit that would be attributable to a particular radicular level or a particular peripheral nerve. The physical therapy was non-certified based on lack of documentation of whether or not the patient has had a trial of physical therapy previously, and lack of documentation of specific body parts to be treated. The California Medical Treatment

Utilization Schedule (MTUS), Chronic Pain Medical Treatment Guidelines, Acupuncture Medical Treatment Guidelines, ACOEM (American College of Occupational and Environmental Medicine) Guidelines and the Official Disability Guidelines (ODG) were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV Bilateral Upper Extremities: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173-174.

Decision rationale: The ACOEM chapter on neck and upper back complaints and special diagnostic studies states: Criteria for ordering imaging studies are: Emergence of a red flag
Physiologic evidence of tissue insult or neurologic dysfunction
Failure to progress in a strengthening program intended to avoid surgery
Clarification of the anatomy prior to an invasive procedure
Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. 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. The assessment may include sensory-evoked potentials (SEPs) if spinal stenosis or spinal cord myelopathy is suspected. If physiologic evidence indicates tissue insult or nerve impairment, consider a discussion with a consultant regarding next steps, including the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, compute tomography [CT] for bony structures). Additional studies may be considered to further define problem areas. The recent evidence indicates cervical disk annular tears may be missed on MRIs. The clinical significance of such a finding is unclear, as it may not correlate temporally or anatomically with symptoms. The provided documentation does not show any signs of emergence of red flags or physiologic evidence of tissue insult or neurologic dysfunction. There is no mention of planned invasive procedures. There are no subtle neurologic findings listed on the physical exam. Sensation is recorded as being intact. For these reasons criteria for special diagnostic testing has not been met per the ACOEM. Therefore the request is not certified.

Physical Therapy 3 Times A Week for 4 Weeks, 12 Visits: 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: The California chronic pain medical treatment guidelines section on physical medicine states: 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) Physical Medicine Guidelines Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks Physical therapy/occupational therapy is a recommended treatment option for chronic ongoing pain per the California MTUS. The goal however of physical therapy is an eventual transition to home exercise. The request would be in excess of the recommended amount of physical therapy sessions per the California MTUS. Therefore the request is not certified.