MAXIMUS Federal Services

Case Number:	CM15-0119020		
Date Assigned:	06/29/2015	Date of Injury:	02/19/2013
Decision Date:	07/28/2015	UR Denial Date:	05/21/2015
Priority:	Standard	Application Received:	06/19/2015

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
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 68 year old female who sustained a work related injury February 19, 2013. According to a primary treating physician's progress report, dated May 5, 2015, the injured worker presented with complaints of left shoulder pain, 3-4/10 and itchiness, constant neck pain, 8-10/10 aggravated by movement, occasional mid back pain, 2/10, and lower back pain, 6/10, which radiates down the right leg. She reports a limp in the left leg. Objective findings included; decreased range of motion in the cervical spine with muscle spasm, bilateral shoulder Neer's positive on the left and Hawkins positive on the left, decreased range of motion and paraspinal musculature tenderness to palpation of the thoracic spine, and decreased range of motion and muscle guarding and spasm of the lumbar spine. Diagnoses are s/p motor vehicle accident 2/15/13 and 2/19/2013, with cervical/thoracic and lumbar spine strains; degenerative disc disease of the cervical and lumbar spines; left shoulder subacromial impingement syndrome (denied 8/28/2014, non-compensable). Treatment plan included medication, pending authorization for a spine and pain management consultation, and at issue, a request for authorization for EMG/NCV (electrodiagnostic and nerve conduction velocity studies) bilateral upper and lower extremities and physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV BUE and BLE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): Special Studies and Diagnostic and Treatment Considerations, pages 177-178; Chapter 12, "Low Back Complaints", Table 12-8, Electrodiagnostics, page 309.

Decision rationale: Per MTUS Guidelines, without specific symptoms or neurological compromise consistent with peripheral neuropathy or entrapment syndrome, radiculopathy, foraminal or spinal stenosis, medical necessity for EMG and NCV has not been established. Submitted reports have not demonstrated any symptoms or clinical findings to suggest any entrapment syndrome or radiculopathy only with continued diffuse tenderness without neurological deficits or specific consistent myotomal or dermatomal correlation to support for the electrodiagnostics. There was no documented failed conservative trial for this chronic injury of 2013 without new injury or acute changed findings. The EMG/NCV BUE and BLE is not medically necessary and appropriate.

PT x 12 Sessions C/S, T/S, L/S: 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 Therapy, pages 98-99.

Decision rationale: Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and functional status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this chronic injury of 2013. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. The PT x 12 Sessions C/S, T/S, L/S is not medically necessary and appropriate.