

<b>Case Number:</b>	CM15-0046931		
<b>Date Assigned:</b>	04/14/2015	<b>Date of Injury:</b>	09/01/2014
<b>Decision Date:</b>	05/28/2015	<b>UR Denial Date:</b>	02/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/12/2015

### 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, Arizona  
 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 55 year old male, who sustained an industrial injury on September 1, 2014. The injured worker was diagnosed as status post open reduction internal fixation left distal radius fracture, rule out intercarpal ligament tear of left wrist, rule out left median and ulnar nerve entrapment neuropathy, cervicothoracic spine strain, lumbar spine strain and left shoulder subacromial impingement syndrome. Treatment to date has included surgery, diagnostic studies, medications and a home exercise program. On January 7, 2015, the injured worker complained of ongoing cervical spine pain without improvement, a mass over his left trapezius musculature, ongoing and slightly increased left wrist/ hand pain with radiation, constant pain in the upper and mid back and low back pain with radiation to the top of his right buttock. His pain was noted to interfere with his activities of daily living, sleep and ability to concentrate. Notes stated that his injury and pain cause severe depression and anxiety all of the time. The treatment plan included EMG/NCS studies of the upper and lower extremities, MRIs, physical therapy, occupational therapy, urinalysis and a follow-up visit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI of Thoracic:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation ODG Neck and Upper Back.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state for most patients presenting with true neck and upper back problems, special studies are not needed unless a 3 to 4 week period of conservative care and observation fails to improve symptoms. In this case, there was no evidence of a sensory or motor deficit to support the necessity for an imaging study. As the medical necessity has not been established, the request is not medically appropriate.

**MRI of Cervical:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Campbell's Operative Orthopedics Vol 1 9th edition, Mosby/Doyma Libros 1998, page 3043.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state for most patients presenting with true neck and upper back problems, special studies are not needed unless a 3 to 4 week period of conservative care and observation fails to improve symptoms. In this case, there was no evidence of a sensory or motor deficit to support the necessity for an imaging study. As the medical necessity has not been established, the request is not medically appropriate.

**Occupational Therapy 3x week x 6 weeks of the Left Hand, Wrist:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation ODG Forearm, Wrist and Hand Chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

**Decision rationale:** California MTUS Guidelines state 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. In this case, the injured worker has completed a previous course of occupational therapy. The medical necessity for additional treatment has not been established in this case. There is no evidence of significant functional improvement following the initial course of treatment. Given the above, the request is not medically necessary.

**EMG of Left Lower Extremity:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state electromyography, including H-reflex test may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks. In this case, there was no documentation of a sensory or motor deficit with regard to the bilateral lower extremities. The medical necessity for the requested electrodiagnostic testing has not been established in this case. Therefore, the request is not medically appropriate.

**NCV of Left Lower Extremity:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state electromyography, including H-reflex test may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks. In this case, there was no documentation of a sensory or motor deficit with regard to the bilateral lower extremities. The medical necessity for the requested electrodiagnostic testing has not been established in this case. Therefore, the request is not medically appropriate.

**NCV of Right Lower Extremity:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state electromyography, including H-reflex test may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks. In this case, there was no documentation of a sensory or motor deficit with regard to the bilateral lower extremities. The medical necessity for the requested electrodiagnostic testing has not been established in this case. Therefore, the request is not medically appropriate.

**EMG of Right Lower Extremity:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state electromyography, including H-reflex test may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks. In this case, there was no documentation of a sensory or motor deficit with regard to the bilateral lower extremities. The medical necessity for the requested electrodiagnostic testing has not been established in this case. Therefore, the request is not medically appropriate.

**NCV of Right Upper Extremity:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state electromyography and nerve conduction velocities may help identify subtle, focal neurologic dysfunction in patients with neck or arm symptoms lasting more than 3 or 4 weeks. In this case, there was no documentation of a significant functional deficit upon examination. There was no evidence of a significant motor or sensory deficit upon examination. The medical necessity has not been established in this case. Therefore, the request is not medically appropriate.

**EMG of Right Upper Extremity:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state electromyography and nerve conduction velocities may help identify subtle, focal neurologic dysfunction in patients with neck or arm symptoms lasting more than 3 or 4 weeks. In this case, there was no documentation of a significant functional deficit upon examination. There was no evidence of a significant motor or sensory deficit upon examination. The medical necessity has not been established in this case. Therefore, the request is not medically appropriate.

**Physical Therapy 3x week x 6 weeks Cervical, Thoracic, Lumbar, and Left Shoulder:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation ODG Physical Therapy Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

**Decision rationale:** California MTUS Guidelines state 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. Treatment for unspecified myalgia and myositis includes 9 to 10 visits over 8 weeks. Treatment for unspecified neuralgia, neuritis, and radiculitis includes 8 to 10 visits over 4 weeks. The current request for 18 sessions of physical therapy exceeds guideline recommendations. Given the above, the request is not medically necessary.

**MRI of Lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Campbell's Operative Orthopedics, Vol 1, 9th edition, Mosby/Doyma Libros 1998 page 3043.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state if physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test. In this case, there was no documentation of a significant motor or sensory deficit upon examination. The medical necessity for the requested imaging study has not been established in this case. Therefore, the request is not medically appropriate.