

<b>Case Number:</b>	CM15-0077484		
<b>Date Assigned:</b>	04/28/2015	<b>Date of Injury:</b>	01/10/2007
<b>Decision Date:</b>	05/26/2015	<b>UR Denial Date:</b>	04/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/22/2015

### 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, Pain Management

### 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 male, who sustained an industrial injury on 1/10/07. He reported pain in the right arm, right thumb, arm, and back. The injured worker was diagnosed as having shoulder joint pain, pelvic/hip pain, knee pain, carpal tunnel syndrome, and lumbar disc with radiculitis. Treatment to date has included a left lumbar transforaminal epidural steroid injection at L4-S1 on 7/13/11, 20 physical therapy sessions, 8 weeks of a functional restoration program, and right carpal tunnel release. A MRI of the shoulder revealed a partial thickness tear of the supraspinatus, a superior labral tear, and degenerative changes of the acromioclavicular joint. A physician's report dated 2/26/15 noted a right sided electromyogram/nerve conduction study revealed right C5-6 radiculopathy. Currently, the injured worker complains of pain in the neck, upper extremity, low back and hip. The treating physician requested authorization for an electromyogram/nerve conduction velocity study for bilateral upper extremities and 6 physical therapy sessions for the right shoulder.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**EMG/NCV of the bilateral upper extremities:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178 and 182. Decision based on Non-MTUS Citation ODG Neck Chapter, Electrodiagnostic Studies, Electromyography, Nerve Conduction Studies.

**Decision rationale:** Regarding the request for EMG/NCS of bilateral upper extremities, Occupational Medicine Practice Guidelines state that the electromyography and nerve conduction velocities 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. Within the documentation available for review, there are no recent physical examination findings identifying subtle focal neurologic deficits, for which the use of electrodiagnostic testing would be indicated. Additionally, it appears the patient recently underwent electrodiagnostic testing of an upper extremity, and there is no statement indicating why additional testing would be needed, or stating what medical decision-making will be based upon the outcome of this test. In the absence of such documentation, the currently requested EMG/NCS of bilateral upper extremities is not medically necessary.

**Physical therapy, 6 sessions, right shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 200. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Physical Therapy.

**Decision rationale:** Regarding the request for additional physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is documentation of completion of prior PT sessions, but there is no documentation of specific objective functional improvement with the previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. Furthermore, the request exceeds the amount of PT recommended by the CA MTUS and, unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested additional physical therapy is not medically necessary.