

<b>Case Number:</b>	CM15-0079029		
<b>Date Assigned:</b>	05/28/2015	<b>Date of Injury:</b>	08/03/2010
<b>Decision Date:</b>	07/02/2015	<b>UR Denial Date:</b>	04/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/24/2015

### 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 (IW) is a 71 year old male who sustained an industrial injury on 08/03/2010. He reported left shoulder pain. The injured worker was diagnosed as having post-concussion syndrome with blurry vision and decreased hearing, chronic left shoulder pain, left biceps tenosynovitis or tear, left shoulder acromioclavicular joint arthritis, chronic neck pain, cervical strain, chronic low back pain, myofascial pain, sleep disturbance, and change in sexual function. Treatment to date has included physical therapy, home exercise, a transcutaneous electrical nerve stimulation (TENS) unit, and medications. On 03/12/2011, the IW had a left shoulder rotator cuff repair. Currently, the injured worker complains of left shoulder pain rated 9/10 radiating to the left trapezius and down the front of the left arm consistent with biceps tenosynovitis pain and to the lateral part of the arm consistent with rotator cuff and articular cartilage pain. He has stiffness of the shoulder, and pain is triggered by 90 degrees abduction. On 08/23/2014, a MRI of the left shoulder situation post rotator cuff repair showed partial tear and re-tear with diffuse muscle fatty atrophy post rotator cuff repair and acromioclavicular degenerative change. There was biceps tendon presumed postoperative change and tendinosis or partial tear. There was superior labrum anterior and posterior lesion extending but not avulsing the biceps and or extending to the anterior, posterior mid and inferior labra. He has Cervical Pain of 7/10 with constant pain radiating to the left and right shoulders with popping on range of motion. The pain is exacerbated by turning the head. The cervical spine shows multilevel degenerative disc disease but no segmental instability. The IW has headaches, and some blurred vision. The pain is 7-9/10 and can last hours resolving spontaneously. A MRI of the brain without contrast was negative for intracranial lesions. Treatment includes continuation of

home exercise program and TENS. Requests were made for: Aqua therapy, EMG/NCS of the upper and lower extremities, Vocational rehab, Flexion/extension cervical x-rays, Referral to PM&R for cervical epidural injections to bilateral C5-C6, and consider third surgery to left shoulder.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Aqua therapy:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy page(s): 22, 99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy Physical medicine page(s): 22, 98-99.

**Decision rationale:** The patient presents with left shoulder pain. The patient is status post left RTC repair from 09/02/2014. The physician is requesting AQUA THERAPY. The RFA dated 03/18/2015 shows a request for aqua therapy. The patient is currently temporarily totally disabled. MTUS Chronic Pain Medical Treatment Guidelines page 22 state, aquatic therapy is recommended as an optional form of exercise therapy where available, as an alternative to land-based physical therapy. Aquatic therapy (including swimming) can minimize effect of gravity, so it is specifically recommended where reduced weight bearing is desirable, for example, extreme obesity. For recommendations on the number of supervised visits, see physical medicine. Water exercise improves some components of health-related quality of life, balance, and stair climbing in females with fibromyalgia, but regular exercise and higher intensities may be required to preserve most of these gains. MTUS pages 98 and 99 have the following: Physical medicine: Recommended as indicated below: Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less). Plus active self-directed home physical medicine. MTUS Guidelines pages 98 and 99 state that for myalgia, myositis, 9 to 10 visits are recommended over 8 weeks, and for neuralgia, neuritis, and radiculitis 8 to 10 visits are recommended. The patient's surgery is from 09/02/2014 and is past the post-surgical timeline. Review of reports show that the patient had physical therapy on 02/12/2015, 03/06/2015, 03/10/2015, 03/13/2015, 03/20/2015, and 03/30/2015 for a total of 6 sessions. Physical therapy report dated 03/06/2015 notes that the patient notes "a lot of pain in his left shoulder, and pain moves up to the left side of the neck as well." The patient has a forward flexed neck posture, retracted bilateral shoulder and swelling over his C4-C5 cervical spine. He was compliant with shoulder activities. The 03/30/2015 PT report shows that there has been not much change over the last few weeks as he continues to have significant pain even at rest. The physician did not provide a rationale for the request and has also noted that "PT did not help." There is no discussion as to why the patient requires weight-reduced exercises. None of the reports mention that the patient is extremely obese. Furthermore, the quantity and duration for the request was not provided. The request IS NOT medically necessary.

**EMG/NCS of the upper and lower extremities:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints page(s): 303, 260. Decision based on Non-MTUS Citation Official disability guidelines neck and upper back (acute and chronic) chapter, EMG.

**Decision rationale:** The patient presents with left shoulder pain. The patient is status post left RTC repair from 09/02/2014. The physician is requesting EMG/NCS OF THE UPPER AND LOWER EXTREMITIES. The RFA dated 03/18/2015 shows a request for EMG/NCS UE's and LE's. The patient is currently temporarily totally disabled. ACOEM Guidelines page 260 states: "appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions such as cervical radiculopathy. This may include nerve conduction studies (NCS) or in more difficult cases, electromyography (EMG) may be helpful. EMG may confirm the diagnosis of CTS but may be normal in early or mild cases of CTS. If the EDS are negative, tests may be repeated later and the course of treatment if symptoms persist. ODG Guidelines on the neck and upper back (acute and chronic) chapter under the section called EMG states that EMG is recommended as an option in select cases. ODG further states regarding EDS in carpal tunnel syndrome, recommended in patients with clinical signs of CTS and may be candidates for surgery. Electrodiagnostic testing includes testing for nerve conduction velocities (NCV), with the additional electromyography (EMG) is not generally necessary." The ACOEM Guidelines Chapter 12 on Low Back Complaints page 303 states that electromyography -EMG- 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 addition, ODG does not recommend NCV. There is minimal justification for performing nerve conduction studies when the patient is presumed to have symptoms on the basis of radiculopathy. The systemic review and meta-analysis demonstrated neurological testing procedures have limited overall diagnostic accuracy in detecting disk herniation with suspected radiculopathy. In the management of spine trauma with radicular symptoms, EMG/NCS often have low combined sensitivity and specificity in confirming root injury. The 03/18/2015 treatment report references an EMG/NCS of the upper extremities dated 02/18/2012. Findings including left sided cervical radiculopathy most likely at C7 with a possibility of C6 involvement. No EMG/NCS reports were provided. The physician also notes that the lumbar area was not accepted a body part per the 12/19/2011 AME. Exam shows tenderness in the bilateral paraspinal areas, suboccipital areas and both trapezii. Positive impingement. Positive Yergason with pain radiating along the biceps. Non-dermatomal decrease in tactile sensory of the left upper extremity. Bilateral paraspinal muscles in the lumbar spine are tender. The request was made to evaluate for radiculopathy. In this case, given the patient's symptoms, an updated EMG/NCS would be appropriate. The request IS medically necessary.

**Flexion/extension cervical x-rays:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Neck and Upper Back Chapter, Flexion/extension imaging studies.

**Decision rationale:** The patient presents with left shoulder pain. The patient is status post left RTC repair from 09/02/2014. The physician is requesting FLEXION/EXTENSION CERVICAL X-RAY. The RFA dated 03/18/2015 shows a request for flexion/extension cervical x-rays. The patient is currently temporarily totally disabled. The ODG Guidelines under the Neck and Upper Back Chapter states, "Not recommended except for indications below. Patients who are alert, have never lost consciousness, are not under the influence of alcohol and/or drugs, have no distracting injuries, have no cervical tenderness, and have no neurologic findings, do not need imaging. Patients who do not fall into this category should have a three-view cervical radiographic series followed by computed tomography (CT). In determining whether or not the patient has ligamentous instability, magnetic resonance imaging (MRI) is the procedure of choice, but MRI should be reserved for patients who have clear-cut neurologic findings and those suspected of ligamentous instability." The 03/18/2015 treatment report references a cervical spine flexion/extension x-ray from 12/19/2011. Results show bridging hypertrophic osteophytes at the endplates posteriorly at C5-C6 contributing to stability at this level. There is a 2mm posterior subluxation of C5 and C6 both on flexion and extension views. The rationale for the request is to "evaluate stability of the cervical spine." In this case, the patient has had previous flexion/extension x-ray that showed 2mm subluxation that did not move. This would indicate a stable segment and there is no need for another set of X-rays absent a new injury. The request IS NOT medically necessary.

**Referral to PM&R for cervical epidural injections to bilateral C5-C6: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections page(s): 46.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ESI page(s): 46-47. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition (2004), Independent medical examination and consultations. Ch: 7, page 127.

**Decision rationale:** The patient presents with left shoulder pain. The patient is status post left RTC repair from 09/02/2014. The physician is requesting REFERRAL TO PM&R FOR CERVICAL EPIDURAL INJECTIONS TO BILATERAL C5-C6. The RFA dated 03/18/2015 shows a request for pending PM&R for cervical epidural. The patient is currently temporarily totally disabled. ACOEM Practice Guidelines, 2nd Edition (2004), page 127 has the following: "The occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise." The MTUS Guidelines page 46 and 47 on epidural steroid injections states that it is recommended as an option for treatment of radicular pain, as defined by pain in a dermatomal distribution with corroborative findings of radiculopathy in an MRI. MTUS also states, "There is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain." Per the 03/18/2015 report, the physician is requesting a referral to PM&R for cervical epidural injections to the bilateral C5-C6.

The 08/09/2011 MRI of the cervical spine was also referenced in this report, showing multilevel DDD most severe at C5-C6 causing significant bilateral right greater than left neural foraminal narrowing and moderate narrowing of the central canal. Exam shows tenderness in the bilateral paraspinal areas, suboccipital areas and both trapezii. Positive impingement. Positive Yergason with pain radiating along the biceps. Non-dermatomal decrease in tactile sensory of the left upper extremity. In this case, the referral to a PM&R for CESI is appropriate given that the patient has satisfied the required criteria for a CESI. The request IS medically necessary.