



## HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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 physician 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/services.

### DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

### CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The underlying date of injury in this case is 1/6/2012. Pertinent diagnoses include cervical muscular ligamentous strain, right upper extremity radiculitis, right shoulder impingement syndrome with tendinitis and myofascial strain, right forearm, wrist, and hand sprain, De Quervain's tenosynovitis, carpal tunnel syndrome, lumbosacral strain, right lower extremity radiculitis, and right knee patellar tendinitis with patellofemoral arthralgia.

The patient is a 67-year-old man. The patient has reported ongoing cervical pain and lumbar pain. The patient has reported radiation of the cervical pain into the right upper extremity and lumbar pain radiating into the right lower extremity and also separate wrist and shoulder pain. The patient has been noted to have positive impingement signs, crepitus and pain in the affected areas.

A prior MRI of the right shoulder of 2/9/2012 demonstrated a labral tear and subacromial impingement felt to be due to cumulative trauma. The treating physician at that time recommended right shoulder arthroscopic evaluation with subacromial decompression.

An MRI of the lumbar spine on 8/28/2013 demonstrated multilevel degeneration with no clear neural impingement.

### IMR DECISION(S) AND RATIONALE(S)

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

#### **1. EMG/NCS to the right upper extremity is not medically necessary and appropriate.**

The Claims Administrator based its decision on the ACOEM Practice Guidelines, Chronic Pain Medical Treatment Guidelines, and Official Disability Guidelines.

The Physician Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM), 2<sup>nd</sup> Edition (2004), Chapter 8, page 178, which is part of the MTUS.

The Physician Reviewer's decision rationale:

ACOEM Guidelines, Chapter 8, Neck, Page 178 recommends "Electromyography and nerve conduction velocities may help identify subtle focal neurological dysfunction in patients with neck or arm symptoms, or both lasting more than 3-4 weeks." This is a very complex case with a multitude of reported diagnoses. It would be difficult to interpret electrodiagnostic studies based on the guidelines without a specific differential diagnosis or clinical question to be answered. Otherwise, there would be a significant risk of false positive findings. Overall, the medical records at this time do not support the requested electrodiagnostic studies.

## **2. IF unit is not medically necessary and appropriate.**

The Claims Administrator based its decision on the ACOEM Practice Guidelines, Chronic Pain Medical Treatment Guidelines, and Official Disability Guidelines.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines (2009), page 118, which is part of the MTUS.

The Physician Reviewer's decision rationale:

California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines section on interferential stimulation, page 118 states "Not recommended as an isolated intervention . . . Possibly appropriate for the following conditions . . . Pain is ineffectively controlled due to diminished effectiveness of medications, or pain that is ineffectively controlled with medications due to side effects or history of substance abuse, or unresponsive to conservative measures." The patient does not appear to meet these criteria. The rationale or indication for this request at this time is not apparent.

## **3. Diagnostic ultrasound of the right shoulder is not medically necessary and appropriate.**

The Claims Administrator based its decision on the ACOEM Practice Guidelines, Chronic Pain Medical Treatment Guidelines, and Official Disability Guidelines.

The Physician Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Physician Reviewer based his/her decision on the Official Disability Guidelines (ODG), Shoulder, Ultrasound.

The Physician Reviewer's decision rationale: This request is not specifically addressed in the California Guidelines. Official Disability Guidelines/Treatment in Workers Compensation/Shoulder states regarding diagnostic ultrasound "Recommended as indicated below . . . The diagnostic accuracy of ultrasound compares well with MRI." This treatment therefore, may be helpful in specific differential diagnostic situations. The current medical records however, outline a large number of diagnoses and it is unclear what specific clinical information is proposed from a diagnostic ultrasound. Given the current available medical records, this request is not medically necessary.

## **4. EMG/NCS to the bilateral lower extremities is not medically necessary and appropriate.**

The Claims Administrator based its decision on the ACOEM Practice Guidelines, Chronic Pain Medical Treatment Guidelines, and Official Disability Guidelines.

The Physician Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM) Guidelines, 2<sup>nd</sup> Edition (2004), Chapter 12, page 303, which is part of the MTUS.

The Physician Reviewer's decision rationale:

ACOEM Guidelines, Second Edition (2004), Chapter Chapter 12, Low Back, Page 303 states "Electromyography may be useful to identify subtle, focal neurological dysfunction in patients with low back symptoms lasting more than 3-4 weeks." This guidelines does not appear to apply to situations such as this were a patient has generalized, or extremely multifocal symptoms. It would be challenging to interpret subtle electrodiagnostic findings in the context of this patient's multiple diagnoses and diffuse symptoms. Based on the available information this request is not supported by the guidelines. This request is not medically necessary.

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[REDACTED]

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