MAXIMUS Federal Services

Case Number:	CM14-0101143		
Date Assigned:	07/30/2014	Date of Injury:	10/13/2011
Decision Date:	09/29/2014	UR Denial Date:	06/25/2014
Priority:	Standard	Application Received:	07/01/2014

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. The expert reviewer is Board Certified in Family Medicine, 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 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

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

This is a 50 year old male patient who reported an industrial injury on 10/13/2011, three (3) years ago, to the neck and upper extremities attributed to the performance of his customary job tasks. The treating physician diagnosed the patient with cervicalgia, right upper extremity radiculopathy, cervical spine degenerative disc disease, spondylosis, and right shoulder pain. The patient complained of ongoing neck and right shoulder pain. The patient reported numbness radiating down the right arm in the third, fourth, and fifth fingers of the right hand. The right shoulder pain was unchanged. The objective findings on examination included diminished range of motion of the cervical spine; tenderness to the trapezial area; decreased sensation to touch of the right fifth finger and decreased grip strength on the right; Tinel's sign negative; right shoulder range of motion decreased and painful. The patient was reported to have not had any physical therapy to the neck in the last year. The treatment plan included 12 additional sessions of physical therapy directed to the neck and upper extremity and EMG/NCV of the bilateral upper extremities with the left utilized to compare to the symptomatic right.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prospective request for 12 physical therapy sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299-300,Chronic Pain Treatment Guidelines PHYSICAL MEDICINE Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck and upper back chapter-PT; back chapter-PT.

Decision rationale: The request is for authorization of an additional twelve (12) sessions of Physical Therapy to the neck, shoulder and upper back 3 years after the date of injury exceeds the number of sessions of PT recommended by the CA MTUS and the time period recommended for rehabilitation. The evaluation of the patient documented no objective findings on examination to support the medical necessity of physical therapy three (3) years after the cited DOS directed to the neck with no documented weakness or muscle atrophy as opposed to a self-directed HEP. There are no objective findings to support the medical necessity of additional PT to the neck and upper back for the rehabilitation of the patient over the number recommended by evidence based guidelines. The patient has received a significant number of sessions of PT directed to the cervical spine. There is no demonstrated medical necessity for the prescribed PT to the neck and upper back three (3) years after the DOI based on the provided documentation. The areas of numbness are not demonstrated to be progressive. The patient is not documented to be in HEP. There is no objective evidence provided by the provider to support the medical necessity of the requested sessions of PT over a self-directed home exercise program as recommended for further conditioning and strengthening. The patient is receiving maintenance PT.The CA MTUS recommend up to nine-ten (9-10) sessions of physical therapy over 8 weeks for the shoulder for sprain/strains. The CA MTUS recommends ten (10) sessions of physical therapy over 8 weeks for the cervical spine rehabilitation subsequent to cervical strain/sprain with integration into HEP. The provider did not provide any current objective findings to support the medical necessity of additional PT beyond the number recommended by evidence based guidelines. The current prescription for additional physical therapy represents maintenance care. There is no demonstrated medical necessity for the requested additional sessions of physical therapy directed to the cervical spine. Therefore, this request is not medically necessary.

Prospective request for 1 EMG/NCV of the bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back (Acute and Chronic), Nerve conduction studies (NCS).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints Page(s): 48; 178; 261; 298, 301, 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and upper back--electromyography; Carpal Tunnel Syndrome--EDS.

Decision rationale: The request for the authorization of the EMG/NCS of the bilateral upper extremities is not supported with sufficient objective clinical findings that would contribute to the future treatment plan of the patient and is not supported by any changes in objective findings documented on examination. There are no documented progressive neurological deficits to

support the medical necessity of Electrodiagnostic studies. The evaluation to rule out a peripheral nerve entrapment or cervical radiculopathy is not supported with the documented objective findings documented on examination. There is no demonstrated medical necessity for the requested electrodiagnostic studies without the failure of conservative treatment. There are no objective or subjective findings documented that require immediate electrodiagnostic studies as no surgical intervention is contemplated and the patient has not failed injections and HEP. The Electrodiagnostic studies were ordered due to continued right hand numbness that was documented on examination. There are only symptoms with objective findings documented for the right upper extremity and no symptoms documented for the left upper extremity. There are no documented changes in the neurological status of the patient that would require Electrodiagnostic studies. The clinical narrative documented that the electrodiagnostic studies were ordered as screening studies. There is no demonstrated medical necessity for the requested EMG/NCS screening examination.The provider has documented no objective findings on examination to be further evaluated with Electrodiagnostic studies prior to the provision of conservative treatment. There are subjective findings; however, there are no significant neurological deficits documented that require Electrodiagnostic studies. The electrodiagnostic test is ordered as a screening test. There is no contemplated surgical intervention for a cervical radiculopathy or peripheral nerve entrapment neuropathy. There is no demonstrated impending surgical intervention being contemplated and the patient has not completed ongoing conservative care. There is no objective evidence that the patient has median or ulnar entrapment neuropathy that would qualify for surgical intervention. The EMG/NCS is for diagnostic purposes for cervical radiculopathy or peripheral nerve compression neuropathy, which are not documented by objective findings. The EMG/NCS would be helpful to assess the medical necessity of a peripheral nerve decompression; however, the patient has not been demonstrated to have failed conservative treatment. There is no medical necessity for the requested electrodiagnostic studies for the evaluation of the patient at this time prior to the provision of conservative treatment. The current clinical objective findings did not demonstrate a significant change in the clinical status of the patient as to nerve entrapment neuropathies and there was not rationale for the requested electrodiagnostic study other than to "rule out" a nerve compression neuropathy or a nerve root impingement neuropathy with a screening study. There were no documented clinical changes or objective findings to support the medical necessity of an EMG/NCS/NCS study. The EMG/NCS would only be necessary to evaluate for the medical necessity of surgical intervention for moderate to severe symptoms with objective findings documented on examination. The criteria recommended by the CA MTUS, the ACOEM Guidelines or the Official Disability Guidelines for the use of electrodiagnostic studies for the BUEs were not documented by the requesting provider. There was no demonstrated objective evidence, such as, a neurological deficit or change in status is that supports the authorization of EMG/NCS studies. There is no demonstrated medical necessity to evaluate for a bilateral upper extremity radiculopathies or peripheral neuropathies based on the objective findings documented. Therefore, this request is not medically necessary.