

Case Number:	CM13-0049518		
Date Assigned:	04/09/2014	Date of Injury:	10/23/2008
Decision Date:	04/22/2015	UR Denial Date:	10/11/2013
Priority:	Standard	Application Received:	11/08/2013

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: New Jersey, Michigan, California
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

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 52-year-old female, who sustained an industrial injury on October 23, 2008. She reported lower back pain. The injured worker was diagnosed as having cervical spine strain/sprain, C4-7 spondylosis and kyphosis, foraminal stenosis, cervical spine/bilateral upper extremity radiculopathy chronic and lumbar spine strain/sprain. Treatment to date has included physical therapy, injections and medications. On November 20, 2014, the injured worker complained of increased numbness in the upper extremities extending from the arms to the fingertips and continued left upper extremity weakness. She continues to drop mostly little items. She also reports intermittent muscle pain and tenderness in the left trapezius. This pain and tenderness extends to and from the left shoulder. She also reports constant thoracic and lumbar spine pain. This pain extends to the bilateral calves with occasional cramping. Physical examination of the cervical spine showed right paraspinal, trapezial and scapular border muscle tenderness on palpation along with spasm. Forward flexion was 30 degrees, extension 30 degrees and lateral bending 10 degrees to the left and 20 degrees to the right. Examination of the lumbar spine revealed paraspinal tenderness to palpation. Forward flexion was 90 degrees, extension 35 degrees and lateral bending 35 degrees. The treatment plan included medication management, physical therapy, possible trigger point injections, diagnostic studies and possible surgical consultation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy (twice a week for four weeks for the cervical and lumbar spine): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

Decision rationale: According to MTUS guidelines, Physical Medicine is recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. 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. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. There is no documentation of the number, efficacy, and outcome of previous physical therapy sessions. There is no recent objective findings that support musculoskeletal dysfunction requiring additional physical therapy. There is no documentation that the patient cannot perform home exercise. Therefore, the request for 8 physical therapy sessions for the cervical and lumbar spine is not medically necessary.

EMG of the Bilateral Upper Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 269.

Decision rationale: According to MTUS guidelines (MTUS page 303 from ACOEM guidelines), "Electromyography (EMG), including H-reflex tests, may be useful to identify

subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks." EMG has excellent ability to identify abnormalities related to disc protrusion (MTUS page 304 from ACOEM guidelines). According to MTUS guidelines, needle EMG study helps identify subtle neurological focal dysfunction in patients with neck and arm symptoms. "When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study Electromyography (EMG), and nerve conduction velocities (NCV), 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" (page 178). EMG is indicated to clarify nerve dysfunction in case of suspected disc herniation (page 182). EMG is useful to identify physiological insult and anatomical defect in case of neck pain (page 179). There is no documentation of peripheral nerve damage, cervical radiculopathy and entrapment neuropathy that requires electrodiagnostic testing. There is no documentation of significant change in the patient condition. Therefore, the request for EMG of The Bilateral Upper Extremities is not medically necessary.

NCV of the Bilateral Upper Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 269.

Decision rationale: According to MTUS guidelines (MTUS page 303 from ACOEM guidelines), "Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks". EMG has excellent ability to identify abnormalities related to disc protrusion (MTUS page 304 from ACOEM guidelines). According to MTUS guidelines, needle EMG study helps identify subtle neurological focal dysfunction in patients with neck and arm symptoms. "When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study Electromyography (EMG), and nerve conduction velocities (NCV), 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" (page 178). EMG is indicated to clarify nerve dysfunction in case of suspected disc herniation (page 182). EMG is useful to identify physiological insult and anatomical defect in case of neck pain (page 179). There is no documentation of peripheral nerve damage, cervical radiculopathy and entrapment neuropathy that requires electrodiagnostic testing. There is no documentation of significant change in the patient condition. Therefore, the request for NCV of The Bilateral Upper Extremities is not medically necessary.