

<b>Case Number:</b>	CM14-0158061		
<b>Date Assigned:</b>	10/01/2014	<b>Date of Injury:</b>	05/01/2014
<b>Decision Date:</b>	12/03/2014	<b>UR Denial Date:</b>	09/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/26/2014

### 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 Anesthesia, has a subspecialty in Acupuncture & Pain 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:

The injured worker is a 42year old claimant with date of injury on 5/1/14 with related neck and low back pain. Per progress report dated 8/26/14, the injured worker complained of neck pain rated 4/10 with stiffness and low back pain rated 6/10 that radiated down the right leg. Per physical exam, there was mild to moderate tenderness in the bilateral cervical paraspinals, trapezius, shoulder, and scapula region. There was moderate tenderness in the right lumbar paraspinals. MRI of the lumbar spine dated 6/26/14 revealed at L4-L5 moderate central canal and prominent bilateral lateral recess/foraminal stenosis; L3-L4 mild central canal and moderate bilateral lateral recess/foraminal stenosis and mild facet arthropathy. Treatment to date has included physical therapy, injections, chiropractic manipulation, and medication management. The date of UR decision was 9/16/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**8 Physical therapy sessions , cervical and lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 98-99.

**Decision rationale:** Per MTUS CPMTG, Physical Medicine guidelines state: Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Myalgia and myositis, unspecified (ICD9 [REDACTED]): 9-10 visits over 8 weeks. Neuralgia, neuritis, and radiculitis, unspecified (ICD [REDACTED]): 8-10 visits over 4 weeks."The records submitted for review state that the patient has already been treated with an unknown amount of physical therapy sessions. The efficacy of these sessions was not documented. Without evidence of functional improvement, further physical therapy visits are not justified and the request is considered not medically necessary.

**EMG right lower extremity:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

**Decision rationale:** The ACOEM guidelines support ordering of imaging studies for emergence of red flags, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. 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. Per MTUS ACOEM page 182, with regard to the detection of neurologic abnormalities, EMG for diagnosis of nerve root involvement if findings of history, physical exam, and imaging study are consistent, is not recommended. Prior MRI has revealed facet arthropathy and disc bulge consistent with symptomatology. The documentation did not note any neurologic deficits. The request is not medically necessary.

**NCS right lower extremity:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

**Decision rationale:** The ACOEM guidelines support ordering of imaging studies for emergence of red flags, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on

physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. 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. Per MTUS ACOEM p182, with regard to the detection of neurologic abnormalities, EMG for diagnosis of nerve root involvement if findings of history, physical exam, and imaging study are consistent is not recommended. Prior MRI has revealed facet arthropathy and disc bulge consistent with symptomatology. The documentation did not note any neurologic deficits. The request is not medically necessary.