

Case Number:	CM14-0192276		
Date Assigned:	11/26/2014	Date of Injury:	03/08/2014
Decision Date:	01/13/2015	UR Denial Date:	11/04/2014
Priority:	Standard	Application Received:	11/17/2014

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 Preventive Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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 38 year old patient with date of injury of 03/08/2014. Medical records indicate the patient is undergoing treatment for rule out cervical and lumbar HNP, rule out cervical and lumbar radiculopathy and right shoulder arthralgia. Subjective complaints include neck pain rated 6-7/10 with pain radiating to upper extremity going to 3 medial fingers, numbness tingling and weakness, mid back pain rated 6-7/10 with occasional right lower extremity numbness to 3 lateral toes. Objective findings include tenderness to palpation of the cervical, thoracic and lumbar spine, cervical range of motion (ROM): flexion 35, extension 40, right and left lateral bend 25, right rotation 70 and left rotation 60; thoracic range of motion flexion 20, extension 10, right and left rotation 25; lumbar ROM flexion 25, extension 5, right and left lateral bend 10, negative Hoffmann's bilaterally, straight leg raise positive on the right, slump test positive on the right, Spurling's positive on the right and right shoulder tender to palpation. Treatment has consisted of physical therapy, corticosteroid injection to the right shoulder and Naproxen. MRI right shoulder 08/19/2014 showed high grade partial thickness bursal surface tear of the supraspinatus anterior leading edge superposed on supraspinatus tendinosis and irregularity of the posterior superior labrum. The utilization review determination was rendered on 11/04/2014 recommending non-certification of EMG/NCS Bilateral Upper Extremity (UE), EMG/NCS Bilateral Lower Extremity (LE) and Chiropractic Therapy, Two Times a Week for Four Weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCS Bilateral Upper Extremity (UE): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation California Code of Regulations, Title 8

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260-262. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Electrodiagnostic testing (EMG/NCS)

Decision rationale: ACOEM States "Appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful." ODG further states regarding carpal tunnel syndrome testing (EMG/NCV), "Recommended in patients with clinical signs of CTS who may be candidates for surgery. Electrodiagnostic testing includes testing for nerve conduction velocities (NCV), but the addition of electromyography (EMG) is not generally necessary. See also Nerve conduction studies (NCS) and Electromyography (EMG). In general, carpal tunnel syndrome should be proved by positive findings on clinical examination and should be supported by nerve conduction tests before surgery is undertaken." ODG further clarifies "NCS is not recommended, but EMG is recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious." The medical documentation provided states that the patient complains of "radiation of pain, numbness, tingling and weakness in the right upper extremity going to the 3 medial fingers" and the treating physician documents that this patient has a positive Spurling's test, both of these are clinical indicators of radiculopathy. The treating physician also spoke with the previous utilization reviewer and agreed to obtain an MRI prior to proceeding to an EMG/NCS. As such, the request for EMG/NCS Bilateral Upper Extremity (UE) is not medically necessary. ODG further clarifies "NCS is not recommended, but EMG is recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious." The medical documentation provided states that the patient complains of "radiation of pain, numbness, tingling and weakness in the right upper extremity going to the 3 medial fingers" and the treating physician documents that this patient has a positive Spurling's test, both of these are clinical indicators of radiculopathy. The treating physician also spoke with the previous utilization reviewer and agreed to obtain an MRI prior to proceeding to an EMG/NCS. As such, the request for EMG/NCS Bilateral Upper Extremity (UE) is not medically necessary.

EMG/NCS Bilateral Lower Extremity (LE): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation California Code of Regulations, Title 8

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303, 309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Electrodiagnostic testing (EMG/NCS)

Decision rationale: ACOEM states "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." ODG states in the Low Back Chapter and Neck Chapter, "NCS is not recommended, but EMG is recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. Electrodiagnostic studies should be performed by appropriately trained Physical Medicine and Rehabilitation or Neurology physicians. See also Monofilament testing". The treating physician documents clinical signs of lumbar radiculopathy "rates her low back pain at 6-7/10 on the pain scale with occasional right lower extremity numbness going to her 3 lateral toes". The treating physician also spoke with the previous utilization reviewer and agreed to obtain an MRI prior to proceeding to an EMG/NCS. As such, the request for EMG/NCS Bilateral Lower Extremity (LE) is not medically necessary.

Chiropractic Therapy, Two Times A Week For Four Weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation California Code of Regulations, Title 8

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Chiropractic, Manipulation

Decision rationale: ODG recommends chiropractic treatment as an option for acute low back pain, but additionally clarifies that "medical evidence shows good outcomes from the use of manipulation in acute low back pain without radiculopathy (but also not necessarily any better than outcomes from other recommended treatments). If manipulation has not resulted in functional improvement in the first one or two weeks, it should be stopped and the patient reevaluated." Additionally, MTUS states "Low back: Recommended as an option. Therapeutic care- Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective /maintenance care - Not medically necessary. Recurrences/flare-ups - Need to reevaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months." Guidelines do recommend chiropractic care as a treatment for low back pain, however there is a recommend trial of 6 visits over 2 weeks with evidence of objective functional improvement. The requested therapy sessions exceeds the guideline recommendations. As such, the request for Chiropractic Therapy, Two Times a Week for Four Weeks is not medically necessary.