

<b>Case Number:</b>	CM14-0058014		
<b>Date Assigned:</b>	07/09/2014	<b>Date of Injury:</b>	04/26/2010
<b>Decision Date:</b>	09/05/2014	<b>UR Denial Date:</b>	04/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/28/2014

### 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 female who reported an industrial injury to the neck and bilateral upper extremities on 2/26/2010 over four (4) years ago, attributed to the performance of her customary job tasks as a hairdresser. The patient was established as permanent and stationary on 11/20/2013. The patient was documented to have received prior sessions of chiropractic care/CMT; PT; and acupuncture. The patient underwent an evaluation with the requesting provider and complained of neck pain radiating to the shoulder, shoulder pain radiating between the shoulder blades; elbow pain, and wrist pain. The objective findings on examination included TTP; decreased ROM to the shoulders, positive impingement sign; positive supraspinatus test bilaterally; tenderness to palpation with decreased range of motion to the cervical spine; elbow with tenderness to palpation bilaterally. The diagnoses included cervical sprain/strain; right shoulder sprain/strain; left shoulder sprain/strain; bilateral elbow sprain/strain; wrist/hand sprain/strain; s/p right shoulder arthroscopic surgery 4/15/14. The treatment plan included physical therapy, which was authorized sessions on 3/10/2014. Subsequent to the authorized physical therapy the patient was prescribed evaluation and treatment with chiropractic therapy directed to the right upper extremity and cervical spine 2x6 additional sessions; acupuncture additional 1x6 sessions; EMG/NCV studies of the bilateral upper extremities; and ESWT to the right Trapezius.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Evaluation and treatment with chiropractic therapy to the right upper extremity and cervical spine, 2X6.: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173, Chronic Pain Treatment Guidelines manual therapy and manipulation Page(s): 58-60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck and upper back chapter-manipulation.

**Decision rationale:** The request for chiropractic care for the cervical spine and right upper extremity (RUE) for the diagnoses of sprain/strain is inconsistent with the recommendations of the CA MTUS and the ACOEM Guidelines. The CA MTUS does not recommend chiropractic care for the upper extremities. There is no medical necessity for chiropractic care CMT to the RUE for the sprain/strain symptoms. There is also no objective evidence to support any chiropractic physiotherapy subsequent to the provided sessions of Physical Therapy as the patient is documented to have received more sessions of chiropractic care/CMT than is recommended by the CA MTUS. The patient should be in a Home Exercise Program (HEP). There is no objective evidence provided to support the medical necessity for the concurrent provision of chiropractic care for the objective findings of TTP. There is also no demonstrated weakness or muscle atrophy. The patient is noted to have prior chiropractic care directed to the neck and upper extremities; however, there is no documented sustained functional improvement with the previously provided sessions of chiropractic care. There is no demonstrated medical necessity of the requested 2x6 sessions chiropractic care. The updated chronic pain chapter of the ACOEM Guidelines only recommends chiropractic treatment for acute and subacute lower back and upper back/neck pain. The patient has chronic lower back pain and the CA MTUS and the ACOEM Guidelines do not recommend maintenance care or periodic treatment plans for flare up care. The ACOEM Guidelines do not recommend the use of chiropractic manipulation for the treatment of chronic lower back/neck pain or for radiculopathies due to nerve root impingement. The ACOEM Guidelines recommend chiropractic manipulation for the treatment of acute/sub-acute lower back pain, but not for chronic back pain as there is no supporting evidence of the efficacy of chiropractic treatment for chronic lower back pain. The updated ACOEM Guidelines (revised 4/07/08) for the lower back do not recommend chiropractic manipulation for chronic lower back pain or for radiculopathy pain syndromes. Chiropractic intervention is recommended by the ACOEM Guidelines during the first few weeks of acute lower back pain or neck pain but not for chronic pain. There is no objective evidence that the patient cannot participate in a self-directed home exercise program for conditioning and strengthening without the necessity of professional supervision. The request for additional sessions 2x6 of chiropractic care/CMT directed to the neck and right upper extremity is not demonstrated to be medically necessary.

## **Acupuncture 1X6.: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** The request for a trial of acupuncture, four sessions without specificity to body parts was made on the initial evaluation of the patient 4 years ago. There was no documentation provided regarding conservative care by the requesting physician prior to the request for acupuncture after it was noted that the patient had received a significant number of sessions of physical therapy. The treating physician requested acupuncture sessions to the neck and RUE based on persistent chronic pain due to the reported industrial injury and muscle pain not controlled with medications and home exercises. The request is not consistent with the recommendations of the CA MTUS for the continued treatment with acupuncture. The patient was noted to have received the recommended number of sessions of acupuncture over a 1-2 month period of treatment. There is no documented sustained functional improvement. The patient is not demonstrated to be participating in a self-directed home exercise program for conditioning and strengthening. The recent clinical documentation demonstrates that the patient has made no improvement to the cited body parts with the provided conservative treatment for the diagnoses of sprain/strain. Acupuncture is not recommended as a first line treatment and is authorized only in conjunction with a documented self-directed home exercise program. There is no documentation that the patient has failed conventional treatment. There was no rationale supporting the use of acupuncture and the treating body parts were not documented. The use of acupuncture is not demonstrated to be medically necessary. An initial short course of treatment to demonstrate functional improvement through the use of acupuncture is recommended for the treatment of chronic pain issues, acute pain, and muscle spasms. A clinical trial of four (4) sessions of acupuncture is consistent with the CA MTUS; the ACOEM Guidelines and the Official Disability Guidelines for treatment of the knee. The continuation of acupuncture treatment would be appropriately considered based on the documentation of the efficacy of the four (4) sessions of trial acupuncture with objective evidence of functional improvement. Functional improvement evidenced by the decreased use of medications, decreased necessity of physical therapy modalities, or objectively quantifiable improvement in examination findings and level of function would support the medical necessity of 8-12 sessions over 4-6 weeks. The request for Acupuncture 1x6 is not medically necessary.

## **Electromyography (EMG) study of the 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-Treatment in Workers' Compensation, Neck & Upper Back Procedure Summary last updated 5/14/2013.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 261. Decision based on Non-MTUS Citation Official Disability

Guidelines (ODG) Neck and upper back chapter, EMG/NCS; carpal tunnel syndrome.

**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. The Electrodiagnostic studies were ordered on the examination which demonstrated no objective findings on examination consistent with neurological deficits to the Bilateral Upper Extremities (BUE). 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 by the requesting physician. There is no demonstrated medical necessity for the requested Electrodiagnostic studies four years after the date of injury with no documented neurological deficits. There are no objective or subjective findings documented that require immediate Electrodiagnostic studies as no surgical intervention is contemplated. The patient has not failed injections and HEP. There are no documented changes in the neurological status of the patient that would require Electrodiagnostic studies for the BUE. 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. The documentation only supports the medical necessity of Electrodiagnostic studies to the left upper extremity to aid in the diagnosis between a cervical radiculopathy or a peripheral nerve entrapment neuropathy. 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 ODG 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 that supports the authorization of EMG/NCS studies. The request is not medically necessary.

**Nerve conduction velocity (NCV) study of the 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-Treatment in Workers' Compensation, Neck & Upper Back Procedure Summary last updated 5/14/2013.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 261. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and upper back chapter--EMG/NCS; carpal tunnel chapter EMG/NCS.

**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. The Electrodiagnostic studies were ordered on the examination which demonstrated no objective findings on examination consistent with neurological deficits to the BUE. 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 by the requesting physician. There is no demonstrated medical necessity for the requested Electrodiagnostic studies four years after the DOI with no documented neurological deficits. The patient has not failed injections or a HEP. There are no documented changes in the neurological status of the patient that would require Electrodiagnostic studies for the BUE. 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. The documentation only supports the medical necessity of Electrodiagnostic studies to the left upper extremity to aid in the diagnosis between a cervical radiculopathy or a peripheral nerve entrapment neuropathy. 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. There is no demonstrated medical necessity to evaluate this request.

**Extracorporeal Shock Wave Therapy (ESWT) to right trapezius.: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment in Workers' Compensation, Shoulder Procedure Summary last updated 12/27/2013.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007), Chapter 9 Shoulder Complaints Page(s): 235; 29; 203. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder---ESWT.

**Decision rationale:** The request for ESWT to the right shoulder/Trapezius and back 2x6 does not provide any objective evidence to support the medical necessity of the requested ESWT. The requested treatment is not demonstrated to be medically necessary and is not consistent with the recommendations of the CA MTUS. There is no rationale provided to support the medical necessity of the requested ESWT. The treatment of the shoulder with ESWT is not recommended by the CA MTUS, the ACOEM Guidelines or the Official Disability Guidelines unless certain criteria are met with specific diagnoses. The provider did not provide any objective evidence to support the use of ESWT for the diagnosed shoulder pain that was demonstrated on the physical examination as only tenderness to palpation. There is no provided objective evidence that the use of ESWT for the symptoms related to the objective findings documented for this patient is medically necessary or leads to functional improvement. There is no demonstrated medical necessity for ESWT to shoulders or back for this patient. The Official Disability Guidelines only recommend the use of ESWT to the shoulder and knee under certain clinical situations directed to the treatment of a calcific tendonitis or a prepatellar bursitis. It is not clear that the requesting provider has demonstrated a failure of conservative care and the decision to proceed with the requested treatment against the recommendations of the currently accepted guidelines is not demonstrated to be medically necessary. The use of conservative treatment must be performed for at least 6 months with documentation of treatment failure. There is no demonstrated medical necessity for the requested ESWT to the right Trapezius.