

<b>Case Number:</b>	CM14-0066971		
<b>Date Assigned:</b>	09/25/2014	<b>Date of Injury:</b>	02/11/2014
<b>Decision Date:</b>	11/24/2014	<b>UR Denial Date:</b>	04/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/12/2014

### 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 Occupational 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 49 year-old male who has reported the gradual onset of widespread pain, attributed to usual work activities, with a listed injury date of 02/11/14. Painful areas are reported to include the neck, back, and all extremities. A 3/31/14 report from a chiropractor lists strain/sprains of the shoulders, neck, and back. The range of motion and muscle testing were performed. There were no details of the clinical history or any other physical findings. No treatment plan was discussed. Per an evaluation by a physician on 03/31/14, the injured worker developed symptoms beginning in 2009. The symptoms included the neck, back, and shoulders, with no mention of any extremity symptoms or specific neurological symptoms. "Difficulty sleeping" was mentioned, with no other psychological symptoms listed or discussed. No prior treatment or evaluations were discussed. The physical examination was notable for multifocal pain, limited spine range of motion, limited shoulder range of motion, positive Tinel's signs at the wrists, and limited wrist range of motion. No specific neurological deficits were listed. The orthopedic diagnoses were of strain/sprains of the spine, shoulders, and upper extremities. PTSD was also listed. The treatment plan included chiropractic treatment, unspecified physical modalities, x-rays of the painful areas to "rule-out fractures/dislocations", EMG/NCS of the upper extremities to rule out radiculopathy and carpal tunnel syndrome, EMG/NCS of the lower extremities to rule out radiculopathy a psychological consultation for "his stress", and a lumbar support. On 4/15/14 Utilization Review non-certified or partially certified the items now under Independent Medical Review. In general, the items that were not certified were not supported by sufficient clinical findings and guidelines. The Official Disability Guidelines and the ACOEM Guidelines were cited. There is no information in the records regarding any prior evaluation or treatment for the injuries under review. For the purposes of this review, the conditions will be evaluated in light of

the ACOEM Guideline portion of the MTUS when applicable, as this portion of the MTUS is used to address initial care, which would be most relevant in this case.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **EMG Bilateral Lower Extremities: 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, Chapter 14 Ankle and Foot Complaints Page(s): 303, 309, 366, 377, 291-5.

**Decision rationale:** There are no reports from the prescribing physician which adequately present the neurologic findings leading to medical necessity for electrodiagnostic testing. Non-specific pain is not an adequate basis for performance of an EMG or NCV. Medical necessity for electrodiagnostic testing is established by a clinical presentation with a sufficient degree of neurologic signs and symptoms to warrant such tests. Based on the available clinical information, there are no neurologic abnormalities and no specific neurologic symptoms. Specific neurological signs were not described in the lower extremities. There has been no trial of conservative care. Based on the current clinical information, there is not sufficient medical necessity for electrodiagnostic testing.

#### **EMG Blateral Upper Extremities: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back chapter electromyography (EMG)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 8 Neck and Upper Back Complaints Page(s): 182, 168-171, 196-201, 213, 268, 272, 269.

**Decision rationale:** There are no reports from the prescribing physician which adequately present the neurologic findings leading to medical necessity for electrodiagnostic testing. Non-specific pain is not an adequate basis for performance of an EMG or NCV. Medical necessity for electrodiagnostic testing is established by a clinical presentation with a sufficient degree of neurologic signs and symptoms to warrant such tests. The MTUS provides specific recommendations for clinical examination, as cited above. Non-specific, non-dermatomal extremity symptoms are not sufficient alone to justify electrodiagnostic testing. Based on the available clinical information, there are no neurologic abnormalities and no specific neurologic symptoms. There has not been a period of conservative care for any proposed carpal tunnel syndrome or radiculopathy, as discussed in the MTUS per the citations above. The necessary findings for carpal tunnel syndrome are not present as outlined in the MTUS. A positive Tinels sign is not an adequate basis for a diagnosis of carpal tunnel syndrome. An EMG is not a test for

carpal tunnel syndrome; it is a test for radiculopathy, although the treating physician has not provided the specific signs and symptoms indicative of radiculopathy. Based on the current clinical information, there is not sufficient medical necessity for any electrodiagnostic testing, including an EMG.

**NCV Bilateral Lower Extremities: 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, Chapter 14 Ankle and Foot Complaints Page(s): 303, 309, 366, 377, 291-5.

**Decision rationale:** There are no reports from the prescribing physician which adequately present the neurologic findings leading to medical necessity for electrodiagnostic testing. Non-specific pain is not an adequate basis for performance of an EMG or NCV. Medical necessity for electrodiagnostic testing is established by a clinical presentation with a sufficient degree of neurologic signs and symptoms to warrant such tests. The MTUS provides specific recommendations for clinical examination, as cited above. Non-specific, non-dermatomal extremity symptoms are not sufficient alone to justify electrodiagnostic testing. Based on the available clinical information, there are no neurologic abnormalities and no specific neurologic symptoms. There has not been a period of conservative care for any proposed radiculopathy or lower extremity condition, as discussed in the MTUS per the citations above. The necessary findings for any lower extremity neurological condition are not present as outlined in the MTUS. An NCV is not a test for radiculopathy, and the treating physician has not provided the specific signs and symptoms indicative of any peripheral neurological condition. Based on the current clinical information, there is not sufficient medical necessity for any electrodiagnostic testing, including an NCV.

**NCV Bilateral Upper Extremities: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back chapter Nerve conduction studies (NCS)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 168-171, 196-201, 213, 268 and 272, 261, 269.

**Decision rationale:** There are no reports from the prescribing physician which adequately present the neurologic findings leading to medical necessity for electrodiagnostic testing. Non-specific pain is not an adequate basis for performance of an EMG or NCV. Medical necessity for electrodiagnostic testing is established by a clinical presentation with a sufficient degree of neurologic signs and symptoms to warrant such tests. The MTUS provides specific recommendations for clinical examination, as cited above. Non-specific, non-dermatomal extremity symptoms are not sufficient alone to justify electrodiagnostic testing. Based on the

available clinical information, there are no neurologic abnormalities and no specific neurologic symptoms. There has not been a period of conservative care for any proposed carpal tunnel syndrome or radiculopathy, as discussed in the MTUS per the citations above. The necessary findings for carpal tunnel syndrome are not present as outlined in the MTUS. A positive Tinels sign is not an adequate basis for a diagnosis of carpal tunnel syndrome. Based on the current clinical information, there is not sufficient medical necessity for any electrodiagnostic testing, including an NCV.

**X-ray of The Thoracic Spine:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 177, 303, 290.

**Decision rationale:** The ACOEM Guidelines 2nd Edition portion of the MTUS provides direction for performing imaging of the spine, as cited above. Per the MTUS citation above, imaging studies are recommended for red flag conditions, physiological evidence of neurological dysfunction, and prior to an invasive procedure. This injured worker had no objective evidence of any of these conditions or indications for an invasive procedure. There has not been a period of conservative care, as discussed in the MTUS. The radiographs are not medically necessary based on the recommendations in the MTUS.

**X-ray of The Bilateral Shoulder, Wrist and Hand:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 208, 200, 254-258, 268-269.

**Decision rationale:** The ACOEM Guidelines, pages 254-258, and pages 207-9, discuss the criteria for imaging of the shoulder and extremity. Special studies are not needed unless there has been a 4-6 week period of conservative care. Exceptions to this rule include the specific bony pathology listed on pages 207 and 268-269, and neurovascular compression. The necessary components of the shoulder and extremity examinations are not present, see the cited ACOEM Guidelines. The available reports do not adequately explain the kinds of conservative care already performed. The injured worker currently has non-specific, non-articular, regional pain, which is not a good basis for performing imaging. The treating physician has not provided sufficient evidence in support of likely intra-articular pathology or the other conditions listed in the MTUS. The imaging is not medically necessary based on the MTUS recommendations.

**Referral to psychology:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation, Chapter 15 Stress Related Conditions Page(s): 22-33, 391-402.

**Decision rationale:** The ACOEM Guidelines pages 22-33 and 391-397 discuss the evaluation of patients in general, and of patients with possible "stress-related conditions". Important history and physical findings are outlined. There is practically none of this sort of information in the available reports. The only mention of any psychological condition in the history is that of difficulty sleeping, which is not an adequate basis for a psychology referral. A diagnosis of PTSD was listed but without any supporting evidence. It is not possible to determine medical necessity for a psychological referral based on the very brief information presented. As with any other specialist referral, the referring physician is expected to provide a sufficient account of signs and symptoms such that medical necessity is established. Although psychiatric conditions are often multifactorial and complex, the major factors can be outlined by a non-psychiatric physician. The referral is not medically necessary based on lack of sufficient evaluation or evidence of a psychiatric condition.

**Chiropractic Treatment, EMS; Massage; Paraffin Wax; Ultrasound:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chronic Pain Treatment Guidelines Manual therapy & manipulation, massage therapy. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)- Forearm, Wrist and Hand- Paraffin Wax Bath

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 173, 181, 299, 308, 58-59, Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-59.

**Decision rationale:** The ACOEM Guidelines state that manipulation is an option in the first few weeks of back pain, and is not proven effective for symptoms lasting longer than one month. Back pain in this case has been present for years, not a month. Per pages 173 and 181 of the ACOEM Guidelines, physical manipulation of the neck and upper back is an optional treatment early in care, and in the context of functional restoration. The ACOEM Guidelines and the chronic pain portion of the MTUS recommend against manipulation for distal extremity symptoms. The request as stated is for an unspecified quantity, potentially open-ended course of chiropractic. The chiropractic may include extremity treatment for which the MTUS does not recommend this kind of care. The longevity of the pain would not qualify this injured worker for chiropractic treatment for the low back. The chiropractic is not medically necessary based on the insufficient prescription and the MTUS recommendations.

**Lumbar Support:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints Page(s): 9, 308.

**Decision rationale:** The ACOEM Guidelines do not recommend lumbar binders, corsets, or support belts as treatment for low back conditions, see page 308. On Page 9 of the Guidelines, The use of back belts as lumbar support should be avoided because they have been shown to have little or no benefit, thereby providing only a false sense of security. The brace is not medically necessary based on the cited guidelines.