

<b>Case Number:</b>	CM14-0072231		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	03/07/2014
<b>Decision Date:</b>	09/24/2014	<b>UR Denial Date:</b>	05/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/19/2014

### 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 Physical Medicine & Rehabilitation and is licensed to practice in Illinois. 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 47-year-old male who reported an injury on 03/07/2014 due to continuous wear of a heavy helmet that eventually caused pain to his neck and his shoulders. The injured worker has diagnoses of chronic pain syndrome, C5-6 and C6-7 cervical radiculopathy, cervical spondylosis with myelopathy, possible sleep apnea, accentuated and aggravated hypertension, carpal tunnel syndrome and lumbar spondyloarthropathy. Past treatment consist of physical therapy and medication therapy. Medications include Trilipix, Crestor 20 mg and ibuprofen 600 mg, the dosage, frequency and duration were not submitted in report. An MRI obtained on 03/26/2014 of the cervical spine revealed a central canal stenosis with minimal left neural foraminal stenosis at C5-6 secondary to a 3 mm left paracentral broad-based disc protrusion. There was straightening of the normal lordotic curvature related to patient positioning or muscle spasm. There were also x-rays taken of the cervical spine that demonstrated degenerative changes including the disc space at C5-6, anterior osteophyte formation at C5-6 and C6-7. The injured worker complained of neck pain and upper back pain which he described as stabbing, shooting, radiating up to the occipital region between the shoulder blades. The injured worker rated the pain at a 4/10 to 5/10 and a 7/10 to 8/10 at its worst. The injured worker also stated that the pain radiated into the left arm, which was aggravated with lifting, moving, forward flexion and abduction. Physical examination dated 04/13/2014 revealed that the injured worker's cervical spine had a range of motion of 70 degrees on forward flexion, 60 degrees on extension, 25 degrees on lateral flexion to the right, 35 degrees on lateral flexion to the left, 60 degrees on rotation to the right and 75 degrees on rotation to the left. Spurling's test was positive and axial compression test were positive on the left with the neck in flexion. There was loss of motor strength and resisted cervical spine range of motion, particularly in the left lateral bending and left rotation. Reflexes of biceps, triceps and brachial

radialis were 2+ bilaterally. The treatment plan is for the injured worker to continue physical therapy, have use a TENS unit, undergo NCV/EMG of the cervical spine, range of motion for the cervical spine, bilateral upper extremities and undergo a sleep study. The rationale and authorization for request were not submitted for review.

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

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

#### **Physical Therapy 2 Times a Week for 3 Weeks: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

**Decision rationale:** The request Physical Therapy 2 Times a Week for 3 Weeks is not medically necessary. Physical examination dated 04/13/2014 revealed that the injured worker's cervical spine had a range of motion of 70 degrees on forward flexion, 60 degrees on extension, 25 degrees on lateral flexion to the right, 35 degrees on lateral flexion to the left, 60 degrees on rotation to the right and 75 degrees on rotation to the left. The California Medical Treatment Utilization Schedule (MTUS) guidelines state that 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. Physical Therapy guidelines allow 9-10 visits over 8 weeks for myalgia and myositis, unspecified, 8-10 visits over 4 weeks for neuralgia, neuritis, and radiculitis, unspecified and 24 visits over 16 weeks for reflex sympathetic dystrophy. Given the above guidelines, the injured worker is not within the MTUS recommended guidelines. The report submitted lacked any evidence of any type of conservative care, medications or active home exercise program. There was also no evidence proven that the injured worker had benefited from past physical therapy sessions. The submitted report lacked progress notes regarding the physical therapy, functional deficits and any of the pertinent information on the injured worker's neck and upper extremities. Additionally, it is not clear as to why the injured worker would not benefit from a home exercise program. Furthermore, the request as submitted did not specify what part of the body would receive the additional physical therapy. As such, the request for physical therapy 2 times a week for 3 weeks is not medically necessary.

#### **Durable Medical Equipment (DME) -TENS Unit and Supplies: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-116.

**Decision rationale:** The request for Durable Medical Equipment (DME) -TENS Unit and Supplies is not medically necessary. The injured worker complained of neck pain and upper back pain which he described as stabbing, shooting, radiating up to the occipital region between the shoulder blades. The injured worker rated the pain at a 4/10 to 5/10 and a 7/10 to 8/10 at its worst. The California Medical Treatment Utilization Schedule (MTUS) guidelines recommend a one month trial of a TENS unit as an adjunct to a program of evidence-based functional restoration for chronic neuropathic pain. Prior to the trial there must be documentation of at least three months of pain and evidence that other appropriate pain modalities have been tried (including medication) and have failed. The proposed necessity of the unit should be documented upon request. Rental would be preferred over purchase during this 30-day. The submitted report lacked quantified evidence that the injured worker had any functional deficits due to neuropathic pain. The submitted documents also lacked evidence of at least 3 months of documented pain and failed conservative care. Guidelines recommend an initial rental of a TENS unit for 30 days before purchase. Furthermore, guidelines also state that proposed necessity and the unit should be documented. Additionally, the request as submitted did not specify where the unit was going to be used. As such, the request for durable medical equipment-TENS unit and supplies is not medically necessary.

**EMG of Cervical Spine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

**Decision rationale:** The request for EMG of Cervical Spine is not medically necessary. The California Medical Treatment Utilization Schedule (MTUS), American College of Occupational and Environmental Medicine (ACOEM) guidelines state that 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. There should be documentation of 3 to 4 weeks of conservative care and observation. Although the injured worker had weakness of the cervical muscles and diminished sensation in the palmar radial aspect of the hand, the submitted report lacked any notations as to the injured worker's previous sessions of physical therapy. Pending results from completed sessions, the medical necessity for the requested EMG of the cervical spine cannot be established. Furthermore, there was no documented evidence submitted in the report revealing that the diagnostics done previously revealed equivocal/long diagnostic findings to necessitate diagnostic study of an EMG. Additionally, the submitted report lacked any evidence of demonstration of failed conservative care received to the injured worker. As such, the request for an EMG of the cervical spine is not medically necessary.

### **NCV of the Cervical Spine: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

**Decision rationale:** The request for Nerve Conduction Velocity (NCV) Left Upper Extremity is not medically necessary. California Medical Treatment Utilization Schedule (MTUS), American College of Occupational and Environmental Medicine (ACOEM) guidelines state that 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. There should be documentation of 3 to 4 weeks of conservative care and observation. Although the injured worker had weakness of the cervical muscles and diminished sensation in the palmar radial aspect of the hand, the submitted report lacked any notations as to the injured worker's previous sessions of physical therapy. Pending results from completed sessions, the medical necessity for the requested NCV of the cervical spine cannot be established. Furthermore, there was no documented evidence submitted in the report revealing that the diagnostics done previously revealed equivocal/long diagnostic findings to necessitate diagnostic study of an NVC. Additionally, the submitted report lacked any evidence of demonstration of failed conservative care received to the injured worker. As such, the request for an NCV of the cervical spine is not medically necessary.

### **ROM of the Cervical Spine and Bilateral Upper Extremities: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Library Of Medicine.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**Decision rationale:** The request for ROM of the Cervical Spine and Bilateral Upper Extremities is not medically necessary. The California Medical Treatment Utilization Schedule (MTUS) guidelines state that 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. Physical Therapy guidelines allow 9-10 visits over 8 weeks for myalgia and myositis, unspecified, 8-10 visits over 4 weeks for neuralgia, neuritis, and radiculitis, unspecified and 24 visits over 16 weeks for reflex sympathetic dystrophy. The MTUS guidelines also stipulate that a therapeutic exercise program should be initiated at the start of any treatment or rehabilitation program, unless exercise is

contraindicated. Such programs should emphasize education, independence, and the importance of an on-going exercise regimen. There is no sufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen. Given the above guidelines, the injured worker is not within the MTUS recommended guidelines. The report submitted lacked any evidence of any type of conservative care, medications or active home exercise program. There was also no evidence provided for review whether the injured worker benefited from previous physical therapy. Report submitted only stated that the injured worker had undergone physical therapy. There was no documentation of outcome or whether the injured worker benefited from such physical therapy. If functional deficit were improved or worsened. Additionally, it was also unclear as to why the injured worker would not benefit from an independent home exercise program. As such, the request is not medically necessary.

**Sleep Study: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Polysomnography.

**Decision rationale:** The request for a Sleep Study is not medically necessary. According to the ODG, Polysomnography is only recommended if there is six months of an insomnia complaint (at least four nights a week), unresponsive to behavior intervention and sedative/sleep-promoting medications, and after psychiatric etiology has been excluded. Not recommended for the routine evaluation of transient insomnia, chronic insomnia, or insomnia associated with psychiatric disorders. Home portable monitor testing may be an option. Insomnia is primarily diagnosed clinically with a detailed medical, psychiatric, and sleep history. Polysomnography is indicated when a sleep-related breathing disorder or periodic limb movement disorder is suspected, initial diagnosis is uncertain, treatment fails, or precipitous arousals occur with violent or injurious behavior. However, Polysomnography is not indicated for the routine evaluation of transient insomnia, chronic insomnia, or insomnia associated with psychiatric disorders. A sleep study for the sole complaint of snoring, without one of the above mentioned symptoms, is not recommended. The submitted report lacked any evidence of 6 months complaint of insomnia with at least 4 nights a week. There also lacked quantified evidence of the injured worker having been unresponsive to behavior intervention and sedatives/sleep promoting medications. There was no mention or documented evidence stating the necessity of the sleep study. Given that the injured worker's sleep complaints are due to chronic pain and based on the evidence-based guidelines, the request as submitted is not medically necessary.