

<b>Case Number:</b>	CM14-0000957		
<b>Date Assigned:</b>	01/22/2014	<b>Date of Injury:</b>	04/15/2013
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	12/13/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/02/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Pennsylvania

Certification(s)/Specialty: Internal Medicine

### 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 38 year old male who has reported neck, upper extremity, back, and lower extremity symptoms after he fell on April 15, 2013. He has been diagnosed with thoracic spine strain, lumbar spine strain, right wrist hand strain, left wrist hand strain, right thigh strain, left thigh strain, and left knee strain. Treatment has included medications, physical and manipulative therapy, and injections. On 11/7/13 the current treating physician evaluated this injured worker. The injured worker had not worked since 8/25/13. There were ongoing multifocal pain symptoms, paresthesias, and mental illness symptoms. Prior treatment had included "physical modalities and prescription medication", which was not discussed further. There was numbness in the wrists, hands, and thighs. Neck pain radiated to the upper back. Low back pain radiated to the right thigh and left knee. The right thigh pain then radiates back to the low back. Hand and wrist pain was present. The physical examination was limited and the findings were of neck and back tenderness, and decreased sensation in the L5 dermatome. Electromyogram/nerve conduction velocity (EMG/NCV) studies from 11/7/13 reportedly showed L5 radiculopathy and bilateral carpal tunnel syndrome. The details of that testing were not provided. Radiographs from 10/10/13, of the thoracic spine, lumbar spine, pelvis, wrists, hands, and knees were listed, and all were normal. The treatment plan was for physical therapy. Subsequent medical reports are of MRIs and shockwave therapy, all performed after the requested services were non-certified in Utilization Review. The specific medical necessity for each of the requested tests and treatments is not present in the available reports. On 12/13/13 Utilization Review non-certified shockwave therapy, electrodiagnostic testing, MRIs, a sleep

study, and a pain management referral. Physical therapy was partially certified. Note was made of the lack of indications for the requested tests and treatments, and the MTUS and the Official Disability Guidelines were cited.

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

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

#### **REFERRAL TO A PAIN MANAGEMENT SPECIALIST: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints, Chapter 14 Ankle and Foot Complaints Page(s): 180,210,375,306.

**Decision rationale:** The MTUS does not provide references to pain management. Some of the body part chapters, as cited above, recommend the option of a physical medicine and rehabilitation (PMR) referral for non-surgical issues. In this case, the treating physician, who is an MD specializing in orthopedic surgeon, has not provided any indications for a referral to pain management. The treating physician has not described any complex pain problems, discussed the prior treatment, or provided reasons that he cannot treat the pain using usual medications and non-surgical modalities. The treating physician made this referral without discussing the failure of usual conservative methods. The referral is not medically necessary based on the lack of specific indications.

#### **SHOCKWAVE THERAPY (LUMBAR, BILATERAL WRISTS) 1X6: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back chapter, Shock wave therapy and Other Medical Treatment Guidelines Aetna Clinical Policy Bulletin: Extracorporeal Shock-Wave Therapy for Musculoskeletal Indications and Soft Tissue Injuries, Number: 0649.

**Decision rationale:** The MTUS does not provide direction for shock wave therapy for low back pain. The Official Disability Guidelines cited above recommend against this therapy based on lack of evidence. It is therefore not medically necessary. The MTUS and the Official Disability Guidelines do not address shockwave therapy for the hand. The Aetna bulletin cited above notes the lack of evidence for shockwave therapy for all orthopedic conditions other than calcific tendinopathy of the shoulder. As such, the request for SHOCKWAVE THERAPY (LUMBAR, BILATERAL WRISTS) 1X6 is not medically necessary.

## **ELECTROMYOGRAPHY(EMG) OF THE BILATERAL LOWER EXTREMITIES:**

Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints Page(s): 182,168-171,303, 309,291-5,268 and 272.

**Decision rationale:** There are no reports from the prescribing physician which adequately describe neurologic findings that necessitate electrodiagnostic testing. Non-specific pain or paresthesias are not an adequate basis for performance of 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, per the citations listed above, outlines specific indications for electrodiagnostic testing, and these indications are based on specific clinical findings. The physician should provide a diagnosis that is likely based on clinical findings, and reasons why the test is needed. The clinical evaluation is minimal and there is no specific neurological information showing the need for electrodiagnostic testing. This injured worker has had prior electrodiagnostic testing that was not discussed by the treating physician. No repeat testing would be indicated absent a significant clinical change as well as a discussion of those test results. Based on the current clinical information, electrodiagnostic testing is not medically necessary, as the treating physician has not provided the specific indications and clinical examination outlined in the MTUS.

## **ELECTROMYOGRAPHY (EMG) OF THE BILATERAL 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 (ODG), Neck and Upper Back.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints Page(s): 182,168-171,303, 309,291-5,268 and 272.

**Decision rationale:** There are no reports from the prescribing physician which adequately describe neurologic findings that necessitate electrodiagnostic testing. Non-specific pain or paresthesias are not an adequate basis for performance of 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, per the citations listed above, outlines specific indications for electrodiagnostic testing, and these indications are based on specific clinical findings. The physician should provide a diagnosis that is likely based on clinical findings, and reasons why the test is needed. The clinical evaluation is minimal and there is no specific neurological information showing the need for electrodiagnostic testing. This

injured worker has had prior electrodiagnostic testing that was not discussed by the treating physician. No repeat testing would be indicated absent a significant clinical change as well as a discussion of those test results. Based on the current clinical information, electrodiagnostic testing is not medically necessary, as the treating physician has not provided the specific indications and clinical examination outlined in the MTUS.

**MRI OF THE THORACIC 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 (ODG), Low Back.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177, 182.

**Decision rationale:** The ACOEM Guidelines 2nd Edition portion of the MTUS provides direction for performing imaging of the spine. 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. The treating physician has not documented any specific neurological deficits or other signs of significant pathology. Per the MTUS, imaging is not generally necessary absent a 3-4 week period of conservative care. The treating physician did not describe an adequate course of conservative care prior to prescribing an imaging study. The prior radiographs were normal for age. The MRI is not medically necessary based on the recommendations in the MTUS.

**MRI OF THE LUMBAR 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 (ODG), Low Back.

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

**Decision rationale:** The treating physician has not described the clinical evidence of significant pathology discussed in the MTUS, such as "Unequivocal objective findings that identify specific nerve compromise on the neurologic examination." No red flag conditions are identified. The treating physician has not provided an adequate clinical evaluation, as outlined in the MTUS ACOEM Guidelines. Per the Official Disability Guidelines citation above, imaging for low back pain is not beneficial in the absence of specific signs of serious pathology. The treating physician has not provided specific indications for performing an MRI. The radiographs were normal for age. MRI of the lumbar spine is not indicated in light of the paucity of clinical findings suggesting any serious pathology; increased or ongoing pain, with or without radiation, is not in itself indication for MRI. An MRI of the lumbar spine is not medically necessary based on lack of sufficient indications per the MTUS and the Official Disability Guidelines.

