

<b>Case Number:</b>	CM14-0125013		
<b>Date Assigned:</b>	08/11/2014	<b>Date of Injury:</b>	04/29/2014
<b>Decision Date:</b>	07/02/2015	<b>UR Denial Date:</b>	07/31/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/07/2014

### 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: Maryland, Texas, Virginia

Certification(s)/Specialty: Internal Medicine, Allergy and Immunology, Rheumatology

### 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 36-year-old female, who sustained an industrial/work injury on 4/29/14. She reported initial complaints of lower back pain. The injured worker was diagnosed as having lumbago, lumbo-sacral sprain, radicular syndrome, cervicgia, and thoracic pain. Treatment to date has included medication, (9) chiropractic visits, diagnostics, and epidural steroid injection. MRI results were reported on 7/31/14 revealed mild degenerative disc disease at L4-5 and L5-S1 with no neural impingement, small high signal intensity zone at the posterior midline aspect, which may represent annular tearing. Currently, the injured worker complains of head, and neck pain with radiation to the left arm as well as pain in the lower back with radiation to the left leg. The pain is associated with tingling in the neck and back, numbness in the neck, and weakness in the left leg and rated 7/10. Per the physician's pain management report on 3/30/15, examination of the cervical spine revealed range of motion forward flexion at 50 degrees, extension at 20 degrees, and rotation at 30 degrees. Exam of the bilateral shoulders reveals normal range of motion. Exam of the lumbar spine reveals forward flexion at 50 degrees, side bending at 30 degrees, and rotation is limited, tenderness to palpation over the bilateral lumbar paraspinal muscles. Current plan of care included continuing medication and further treatment. The requested treatments include 8 chiropractic visits to include EMS (electrical muscle stimulation), manual therapy and intersegmental traction, 1 Lumbar MRI, and 1 NCV/EMG.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**8 chiropractic visits to include EMS (electrical muscle stimulation), manual therapy and intersegmental traction: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation.

**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." Medical documents indicate that patient has undergone approximately 9 previous chiropractic sessions, which would not be considered in the "trial period" anymore. The treating provider has not demonstrated evidence of objective and measurable functional improvement during or after the trial of therapeutic care to warrant continued treatment. As such, the request for 8 chiropractic visits to include EMS (electrical muscle stimulation), manual therapy and intersegmental traction is not medically necessary.

**1 Lumbar MRI: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Chiropractic, Manipulation.

**Decision rationale:** MTUS and ACOEM recommend MRI, in general, for low back pain when "cauda equine, tumor, infection, or fracture are strongly suspected and plain film radiographs are negative, MRI test of choice for patients with prior back surgery." ACOEM additionally recommends against MRI for low back pain "before 1 month in absence of red flags." ODG states, "Imaging is indicated only if they have severe progressive neurologic impairments or signs or symptoms indicating a serious or specific underlying condition, or if they are candidates for invasive interventions. Immediate imaging is recommended for patients with major risk factors for cancer, spinal infection, cauda equina syndrome, or severe or progressive neurologic deficits. Imaging after a trial of treatment is recommended for patients who have minor risk factors for cancer, inflammatory back disease, vertebral compression fracture, radiculopathy, or symptomatic spinal stenosis. Subsequent imaging should be based on new symptoms or changes in current symptoms." The medical notes provided did not document

(physical exam, objective testing, or subjective complaints) any red flags, significant worsening in symptoms or other findings suggestive of the pathologies outlined in the above guidelines. As such, the request for 1 lumbar MRI is not medically necessary.

**1 NCV/EMG: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 3030, 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." Medical records do not indicate clinical obvious radiculopathy or physical exam findings concerning for radiculopathy. MRI performed on 7/31/14 is not consistent with radiculopathy. NCS are not recommended. As such, the request for 1 NCV/EMG is not medically necessary.