

<b>Case Number:</b>	CM14-0136717		
<b>Date Assigned:</b>	09/03/2014	<b>Date of Injury:</b>	07/09/2013
<b>Decision Date:</b>	05/05/2015	<b>UR Denial Date:</b>	07/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/25/2014

### 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: Texas, New York, California  
 Certification(s)/Specialty: Preventive Medicine, Occupational 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 applicant is a represented 30-year-old who has filed a claim for chronic neck pain, shoulder pain, and low back pain with derivative complaints of posttraumatic headaches reportedly associated with an industrial injury of July 9, 2013. In a Utilization Review report dated July 20, 2014, the claims administrator failed to approve requests for electrodiagnostic testing of the left lower extremity, a diagnostic ultrasound of the shoulder, and 12 sessions of chiropractic manipulative therapy. The 12 sessions of chiropractic manipulative therapy were partially approved as six sessions of the same. A lumbar MRI was also apparently denied. The claims administrator referenced a July 11, 2014 progress note in its determination. The applicant's attorney subsequently appealed. In a March 25, 2015 progress note, the applicant reported ongoing complaints of shoulder pain and low back pain. Limited range of motion about the shoulder was noted with flexion to 100 degrees. The applicant was placed off of work, on total temporary disability, for an additional six weeks while additional physical therapy, a lumbar spine surgery consultation, and an epidural steroid injection were endorsed. On September 17, 2014, the applicant again reported ongoing complaints of low back pain. Electrodiagnostic testing of the left upper and left lower extremity was proposed, along with MRI imaging of the cervical spine and a diagnostic ultrasound of the left shoulder. The applicant, once again, was placed off of work, on total temporary disability. In a letter dated October 28, 2014, the attending provider alluded to lumbar MRI imaging demonstrating an L5-S1 right paracentral disk protrusion impinging upon the descending S1 nerve root. An L4-L5 disk protrusion was also generating associated impingement upon the left L4 nerve root, it was acknowledged.

Epidural steroid injection therapy was endorsed. In an appeal letter dated January 2, 2015, the attending provider reiterated his request for additional chiropractic manipulative therapy, a TENS unit, a urine drug screen, and an epidural steroid injection. In an RFA form dated February 19, 2015, the attending provider seemingly went on to seek authorization for a neurosurgical consultation for low back pain on the grounds that the applicant had failed conservative treatment, including time, medications, physical therapy, epidural steroid injection therapy, etc. In an associated progress note of February 19, 2015, the applicant was again placed off of work, on total temporary disability, for an additional four to six weeks.

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

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

#### **MRI of the Lumbar Spine: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation ACOEM Guidelines, Chapter 12, Low Back Complaints, 2007, pg 53.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304.

**Decision rationale:** Conversely, the request for MRI imaging of the lumbar spine was medically necessary, medically appropriate and indicated here. As noted in the MTUS Guideline in ACOEM Chapter 12, page 304, imaging studies should be reserved for cases in which surgery is being considered or red flag diagnoses are being evaluated. Here, the lumbar MRI in question was apparently performed on October 25, 2014 and was apparently positive for disk protrusions at L4-L5 and L5-S1 with associated nerve root impingement. The applicant went on to receive epidural steroid injection therapy and, ultimately, neurosurgery consultation based on the outcome of the positive lumbar MRI. Thus, the MRI of the lumbar spine in question did apparently influence the treatment plan, was positive and did ultimately lead to the applicant's pursuing a neurosurgical consultation based on the outcome of the same. Therefore, the request was medically necessary.

#### **EMG/NCV of Left Lower Extremity: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

**Decision rationale:** No, the request for EMG-NCV testing of the left lower extremity was not medically necessary, medically appropriate, or indicated here. As noted in the MTUS Guideline in ACOEM Chapter 12, Table 12-8, page 309, EMG testing is deemed "not recommended" for applicants who carry a diagnosis of clinically obvious radiculopathy, as was seemingly present here. The applicant already had a clinically evident, radiographically confirmed lumbar

radiculopathy with disk protrusions at the L4-L5 and L5-S1 levels which the attending provider felt were significantly enough to move forward with epidural steroid injection therapy. When lumbar epidural steroid therapy failed, the attending provider went on to seek a neurosurgery consultation on February 19, 2015. Thus, all evidence on file pointed to the applicant's already having an established diagnosis of clinically evident, radiographically confirmed lumbar radiculopathy, effectively obviating the need for the left lower extremity electrodiagnostic testing at issue. Therefore, the request was not medically necessary.

### **1 Diagnostic Ultrasound of the Left Shoulder: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 214.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208.

**Decision rationale:** Similarly, the request for a diagnostic ultrasound of the shoulder was not medically necessary, medically appropriate or indicated here. While the MTUS does not specifically address the topic of ultrasound testing of the shoulder, the MTUS Guideline in ACOEM Chapter 9, page 208 notes that one of the primary criteria for pursuit of an imaging study is clarification of anatomy prior to an invasive procedure. Here, there was neither an explicit statement (nor an implicit expectation) that the applicant would act on the results of the proposed shoulder ultrasound and/or consider a surgical intervention based on the outcome of the same. Little to no applicant specific rationale accompanied the request for testing. It is further noted that the attending provider failed to reconcile his request for diagnostic ultrasound testing for the shoulder with his later request on February 19, 2015 for MRI imaging of the shoulder, which, if positive, would obviate the need for the shoulder ultrasound testing in question. Therefore, the request was not medically necessary.

### **12 sessions of Chiropractic Manipulation: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): s 59-60.

**Decision rationale:** Similarly, the request for 12 sessions of chiropractic manipulative therapy was likewise not medically necessary, medically appropriate or indicated here. While pages 59 and 60 of the MTUS Chronic Pain Medical Treatment Guidelines do support up to 24 sessions of chiropractic manipulative therapy in applicants who demonstrate treatment success by achieving and/or maintaining successful return to work status, in this case, however, the applicant was off of work, on total temporary disability, as of the date of the request. The attending provider ultimately went to seek authorization for a neurosurgery consultation on the grounds that earlier conservative treatment, including earlier chiropractic manipulative therapy had, in fact, proven unsuccessful. Additional chiropractic manipulative therapy, thus, was not indicated in the face

of the applicant's seeming failure to return to work despite receipt of earlier manipulative therapy in unspecified amounts over the course of the claim. Therefore, the request was not medically necessary.