

<b>Case Number:</b>	CM14-0189498		
<b>Date Assigned:</b>	11/20/2014	<b>Date of Injury:</b>	08/26/2014
<b>Decision Date:</b>	01/08/2015	<b>UR Denial Date:</b>	10/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/13/2014

### 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 Preventive Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Texas. 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 39 year old male who was injured at work on 08/26/2014. He is reported to be complaining of lower back pain that radiates to the right buttocks, hip, and leg. The pain is associated with numbness and tingling. The pain worsens with prolonged sitting and standing, and sitting on hard surfaces. In addition, he complained of pain in his right knee and right wrist; weakness, loss of strength and mobility of his legs, right more than the left; swelling of the knees and loss of motion. The physical examination revealed limited range of motion of the lumbar spine, muscle splinting, and tenderness to touch at the sacroiliac areas, and the paraspinal muscles; positive bilateral straight leg tests at 30 degrees; weakness of the muscles of the lower extremities; The worker has been diagnosed of right wrist sprain/strain, lumbar sprain/strain rlo IVD, right knee sprain/strain. Treatments have included Chiropractic Care, Physical Therapy, Acupuncture, Tramadol, extra strength Tylenol. At dispute are the requests for Ortho Referral; Shockwave Therapy x4 for Lumbar Spine; NCV/EMG lower extremity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ortho Referral:** Overturned

**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): 305.

**Decision rationale:** The injured worker sustained a work related injury on 08/26/2014. The medical records provided indicate the diagnosis of right wrist sprain/strain, lumbar sprain/strain rlo IVD, right knee sprain/strain. Treatments have included Chiropractic Care, Physical Therapy, Acupuncture, Tramadol, extra strength Tylenol. The medical records provided for review do indicate a medical necessity for Ortho Referral for the lumbar disorder. The MTUS does recommend surgical referral in individuals with low back complaints with severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise; or in individuals with activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms; and in individuals with clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair; or in individuals with failure of conservative treatment to resolve disabling radicular symptoms. The records reviewed the injured worker has radicular low back pain accompanied with both subjective and objective lower extremity weakness, as well as positive findings in the lower extremity Electromyography. Therefore, the request for Orthopedic Referral is both medically necessary and appropriate.

**Shockwave Therapy x4 for Lumbar Spine:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 30 and 308-309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Extracorporeal shockwave therapy (ESWT).

**Decision rationale:** The injured worker sustained a work related injury on 08/26/2014. The medical records provided indicate the diagnosis of right wrist sprain/strain, lumbar sprain/strain rlo IVD, right knee sprain/strain. Treatments have included Chiropractic Care, Physical Therapy, Acupuncture, Tramadol, extra strength Tylenol. The medical records provided for review do not indicate a medical necessity for Shockwave Therapy x4 for Lumbar Spine. Both the MTUS the Official Disability Guidelines discussed shockwave therapy under the elbow chapter. Both guidelines recommend against its use. Additionally, the MTUS does not have shockwave as one of the listed treatment modalities in the summary of recommendations for treatment of low back complaints. Therefore, the requested treatment is not medically necessary and appropriate.

**NCV/EMG 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): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG);

Low Back - Lumbar & Thoracic (Acute & Chronic), EMGs/NCS (electromyography and Nerve conduction studies).

**Decision rationale:** The injured worker sustained a work related injury on 08/26/2014. The medical records provided indicate the diagnosis of right wrist sprain/strain, lumbar sprain/strain rlo IVD, right knee sprain/strain. Treatments have included chiropractic care, physical therapy, acupuncture, Tramadol, extra strength Tylenol. The medical records provided for review do not indicate a medical necessity for NCV/EMG lower extremity. While the Official Guidelines recommends needle electromyography in equivocal cases of low back radiculopathy, it recommends against its use in cases where radiculopathy is already obvious, as in this case with radicular symptoms and objective evidence of positive straight leg raise and lower extremity weakness, all in support of radiculopathy. Furthermore, the MTUS does not recommend lower extremity nerve studies. Therefore, the requested test is not medically necessary and appropriate.