

Case Number:	CM14-0039797		
Date Assigned:	08/08/2014	Date of Injury:	02/21/2013
Decision Date:	01/30/2015	UR Denial Date:	03/26/2014
Priority:	Standard	Application Received:	04/04/2014

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 Occupational Medicine and is licensed to practice in California. 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:

According to the records made available for review, this is a 40-year-old female with a 2/21/13 date of injury. At the time (1/31/14) of request for authorization for Magnetic Resonance Imaging of the cervical/lumbar spine, Electromyography testing of bilateral upper extremities, Nerve Conduction Velocity testing of bilateral upper extremities, Chiro treatment x 24 sessions, Physical Therapy x 24 sessions, Electromyography of the Lower extremities, and Nerve conduction studies of the lower extremities, there is documentation of subjective (neck and low back pain associated with numbness and tingling in bilateral arms, legs, and feet) and objective (tenderness over the lumbar paraspinal area, normal leg sensation, negative straight leg raising test, and normal upper extremities reflexes) findings, imaging findings (reported MRI of the lumbar spine (undated) revealed increased disc 2.5 mm at L5-S1 with neuroforaminal narrowing and mild scoliosis; report not available for review)), current diagnoses (cervical disc displacement, lumbar sprain/strain, lumbar herniated disc syndrome without myelopathy, and lumbar radiculitis with radiculopathy to both lower extremities), and treatment to date (medications (including ongoing treatment with Tramadol, Ibuprofen, and Tylenol) and previous physical therapy treatments). Regarding cervical MRI, there is no specific (to a nerve root distribution) documentation of physiologic evidence of tissue insult or neurologic dysfunction. Regarding lumbar MRI, there is no documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a repeat study is indicated (to diagnose a suspected fracture or suspected dislocation, to monitor a therapy or treatment which is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment (repeat imaging is not appropriate solely to determine the efficacy of physical therapy or chiropractic treatment), to follow up a surgical procedure, to diagnose a change in the patient's condition marked by new or altered physical findings). Regarding

EMG/NCV testing of bilateral upper extremities, there is no documentation of objective findings consistent with radiculopathy/nerve entrapment, failure of additional conservative treatments (physical modalities), and that the etiology of the radicular symptoms is not explained by MRI or other diagnostic studies. Regarding physical therapy, the number of previous physical therapy treatment sessions cannot be determined; and there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of physical therapy provided to date. Regarding EMG/NCV of bilateral lower extremities, there is no documentation of focal neurologic dysfunction with low back symptoms lasting more than three to four weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Magnetic Resonance Imaging of the cervical/lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 179-183; 303-304. Decision based on Non-MTUS Citation Other Medical Treatment Guidelines: Official Disability Guidelines (ODG) Minnesota Rules, 5221.6100 Parameters for Medical Imaging.

Decision rationale: Specifically regarding cervical MRI, MTUS reference to ACOEM Guidelines identifies documentation of red flag diagnoses where plain film radiographs are negative, physiologic evidence (in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans) of tissue insult or neurologic dysfunction, failure of conservative treatment; or diagnosis of nerve root compromise, based on clear history and physical examination findings, in preparation for invasive procedure; as criteria necessary to support the medical necessity of an MRI. Specifically regarding lumbar MRI, MTUS reference to ACOEM guidelines identifies documentation of red flag diagnoses where plain film radiographs are negative; objective findings that identify specific nerve compromise on the neurologic examination, failure of conservative treatment, and who are considered for surgery, as criteria necessary to support the medical necessity of MRI. ODG identifies documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a repeat study is indicated (such as: To diagnose a suspected fracture or suspected dislocation, to monitor a therapy or treatment which is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment (repeat imaging is not appropriate solely to determine the efficacy of physical therapy or chiropractic treatment), to follow up a surgical procedure, to diagnose a change in the patient's condition marked by new or altered physical findings) as criteria necessary to support the medical necessity of a repeat MRI. Within the medical information available for review, there is documentation of diagnoses of cervical disc displacement, lumbar sprain/strain, lumbar herniated disc syndrome without myelopathy, and lumbar radiculitis with radiculopathy to both lower extremities. In addition, there is documentation of failure of conservative treatment (medications). However, given

documentation of associated requests for Chiro treatment x 24 sessions and Physical Therapy x 24 sessions, there is no documentation of failure of additional conservative treatments (physical modalities). In addition, given documentation of objective (normal leg sensation, negative straight leg raising test, and normal upper extremities reflexes) findings, specifically for cervical MRI, there is no specific (to a nerve root distribution) documentation of physiologic evidence of tissue insult or neurologic dysfunction; and, specifically for repeat lumbar MRI, a diagnosis/condition (with supportive subjective/objective findings) for which a repeat study is indicated (to diagnose a suspected fracture or suspected dislocation, to monitor a therapy or treatment which is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment (repeat imaging is not appropriate solely to determine the efficacy of physical therapy or chiropractic treatment), to follow up a surgical procedure, to diagnose a change in the patient's condition marked by new or altered physical findings). Therefore, based on guidelines and a review of the evidence, the request for Magnetic Resonance Imaging of the cervical/lumbar spine is not medically necessary.

Electromyography testing of bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 10 Elbow Disorders (Revised 2007) Page(s): 177; 33. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Electrodiagnostic studies (EDS).

Decision rationale: MTUS reference to ACOEM identifies documentation of subjective/objective findings consistent with radiculopathy/nerve entrapment that has not responded to conservative treatment, as criteria necessary to support the medical necessity of EMG/NCV. ODG identifies that EMG is useful in cases where clinical findings are unclear, there is a discrepancy in imaging, or to identify other etiologies of symptoms. Within the medical information available for review, there is documentation of diagnoses of cervical disc displacement, lumbar sprain/strain, lumbar herniated disc syndrome without myelopathy, and lumbar radiculitis with radiculopathy to both lower extremities. In addition, there is documentation of failure of conservative treatment medications). However, despite documentation of subjective (neck associated with numbness and tingling in bilateral arms) findings, and given objective (normal upper extremities reflexes) findings, there is no documentation of objective findings consistent with radiculopathy/nerve entrapment. In addition, given documentation of associated requests for Chiro treatment x 24 sessions and Physical Therapy x 24 sessions, there is no documentation of failure of additional conservative treatments (physical modalities). Furthermore, given documentation of an associated request for MRI of the cervical spine, there is no documentation that the etiology of the radicular symptoms is not explained by MRI or other diagnostic studies. Therefore, based on guidelines and a review of the evidence, the request for Electromyography testing of bilateral upper extremities is not medically necessary.

Nerve Conduction Velocity testing of bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 10 Elbow Disorders (Revised 2007) Page(s): 177; 33. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Electrodiagnostic studies (EDS).

Decision rationale: MTUS reference to ACOEM identifies documentation of subjective/objective findings consistent with radiculopathy/nerve entrapment that has not responded to conservative treatment, as criteria necessary to support the medical necessity of EMG/NCV. ODG identifies that EMG is useful in cases where clinical findings are unclear, there is a discrepancy in imaging, or to identify other etiologies of symptoms. Within the medical information available for review, there is documentation of diagnoses of cervical disc displacement, lumbar sprain/strain, lumbar herniated disc syndrome without myelopathy, and lumbar radiculitis with radiculopathy to both lower extremities. In addition, there is documentation of failure of conservative treatment medications). However, despite documentation of subjective (neck associated with numbness and tingling in bilateral arms) findings, and given objective (normal upper extremities reflexes) findings, there is no documentation of objective findings consistent with radiculopathy/nerve entrapment. In addition, given documentation of associated requests for Chiro treatment x 24 sessions and Physical Therapy x 24 sessions, there is no documentation of failure of additional conservative treatments (physical modalities). Furthermore, given documentation of an associated request for MRI of the cervical spine, there is no documentation that the etiology of the radicular symptoms is not explained by MRI or other diagnostic studies. Therefore, based on guidelines and a review of the evidence, the request for Nerve Conduction Velocity testing of bilateral upper extremities is not medically necessary.

Chiro treatment x 24 sessions: 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): 298-299, Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58.

Decision rationale: MTUS reference to ACOEM identifies documentation of objective functional deficits and functional goals as criteria necessary to support the medical necessity of chiropractic treatment. In addition, MTUS Chronic Pain Medical Treatment Guidelines supports a trial of 6 visits, with evidence of objective functional improvement, total of up to 18 visits. Within the medical information available for review, there is documentation of diagnoses of cervical disc displacement, lumbar sprain/strain, lumbar herniated disc syndrome without myelopathy, and lumbar radiculitis with radiculopathy to both lower extremities. In addition, there is documentation of functional deficits and functional goals. However, the requested

number of treatments exceeds guidelines (for an initial trial). Therefore, based on guidelines and a review of the evidence, the request for Chiro treatment x 24 sessions is not medically necessary.

Physical Therapy x 24 sessions: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Physical therapy (PT). Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines support a brief course of physical medicine for patients with chronic pain not to exceed 10 visits over 4-8 weeks with allowance for fading of treatment frequency, with transition to an active self-directed program of independent home physical medicine/therapeutic exercise. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG recommends a limited course of physical therapy for patients with a diagnosis of lumbosacral neuritis/radiculitis not to exceed 12 visits over 8 weeks. ODG also notes patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy) and when treatment requests exceeds guideline recommendations, the physician must provide a statement of exceptional factors to justify going outside of guideline parameters. Within the medical information available for review, there is documentation of diagnoses of cervical disc displacement, lumbar sprain/strain, lumbar herniated disc syndrome without myelopathy, and lumbar radiculitis with radiculopathy to both lower extremities. In addition, there is documentation of previous physical therapy treatments. Furthermore, given documentation of subjective (low back pain associated with numbness and tingling in bilateral legs and feet) and objective (tenderness over the lumbar paraspinal area) findings, there is documentation of functional deficits and functional goals. However, there is no documentation of the number of previous treatments to determine if guidelines has already been exceeded or will be exceeded with the additional request and, if the number of treatments have exceeded guidelines, remaining functional deficits that would be considered exceptional factors to justify exceeding guidelines. In addition, given documentation of previous physical therapy treatments, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of physical therapy provided to date. Therefore, based on guidelines and a review of the evidence, the request for Physical Therapy x 24 sessions is not medically necessary.

Electromyography of the Lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS 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, Electrodiagnostic studies.

Decision rationale: MTUS reference to ACOEM guidelines identifies documentation of focal neurologic dysfunction in patients with low back symptoms lasting more than three to four weeks, as criteria necessary to support the medical necessity of electrodiagnostic studies. ODG identifies documentation of evidence of radiculopathy after 1-month of conservative therapy, as criteria necessary to support the medical necessity of electrodiagnostic studies. In addition, ODG does not consistently support performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Furthermore, ODG identifies that EMG is useful in cases where clinical findings are unclear, there is a discrepancy in imaging, or to identify other etiologies of symptoms. Within the medical information available for review, there is documentation of diagnoses of cervical disc displacement, lumbar sprain/strain, lumbar herniated disc syndrome without myelopathy, and lumbar radiculitis with radiculopathy to both lower extremities. However, despite documentation of subjective (low back pain associated with numbness and tingling in bilateral arms, legs, and feet) findings, and given objective (normal leg sensation and negative straight leg raising test) findings, there is no documentation of focal neurologic dysfunction with low back symptoms lasting more than three to four weeks. In addition, given documentation of an associated request for MRI of the lumbar spine, there is no documentation that the etiology of the radicular symptoms is not explained by MRI or other diagnostic studies. Therefore, based on guidelines and a review of the evidence, the request for Electromyography of the Lower extremities is not medically necessary.

Nerve conduction studies of the lower extremities.: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS 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, Electrodiagnostic studies.

Decision rationale: MTUS reference to ACOEM guidelines identifies documentation of focal neurologic dysfunction in patients with low back symptoms lasting more than three to four weeks, as criteria necessary to support the medical necessity of electrodiagnostic studies. ODG identifies documentation of evidence of radiculopathy after 1-month of conservative therapy, as criteria necessary to support the medical necessity of electrodiagnostic studies. In addition, ODG does not consistently support performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Furthermore, ODG identifies that EMG is useful in cases where clinical findings are unclear, there is a discrepancy in imaging, or to identify other etiologies of symptoms. Within the medical information available for review, there is documentation of diagnoses of cervical disc displacement, lumbar sprain/strain, lumbar

herniated disc syndrome without myelopathy, and lumbar radiculitis with radiculopathy to both lower extremities. However, despite documentation of subjective (low back pain associated with numbness and tingling in bilateral arms, legs, and feet) findings, and given objective (normal leg sensation and negative straight leg raising test) findings, there is no documentation of focal neurologic dysfunction with low back symptoms lasting more than three to four weeks. In addition, given documentation of an associated request for MRI of the lumbar spine, there is no documentation that the etiology of the radicular symptoms is not explained by MRI or other diagnostic studies. Therefore, based on guidelines and a review of the evidence, the request for Nerve conduction studies of the lower extremities is not medically necessary.