

<b>Case Number:</b>	CM15-0003944		
<b>Date Assigned:</b>	01/15/2015	<b>Date of Injury:</b>	03/25/2011
<b>Decision Date:</b>	03/23/2015	<b>UR Denial Date:</b>	12/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/08/2015

### 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: California, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 64-year-old female who reported an injury on 03/25/2011. The mechanism of injury was not specifically stated. The current diagnoses include degeneration of cervical intervertebral disc, cervical radiculitis, and cervical disc displacement. The injured worker presented on 11/19/2014 for an initial pain management consultation. The injured worker presented with complaints of low back and neck pain. Previous conservative treatment included ice therapy, heat therapy, NSAIDs, and opioid medication. The current medication regimen includes tramadol 50 mg, Lidoderm 5% patch, and Robaxin 750 mg. upon examination, there was paralumbar spasm, 2+ tenderness to palpation, atrophy of the quadriceps, diminished lumbar range of motion, positive straight leg raising at 40 degrees bilaterally, absent deep tendon reflexes at the bilateral knees, decreased sensation in the bilateral lower extremities, and 5/5 motor strength in the bilateral lower extremities. Examination of the cervical spine revealed limited range of motion, 5/5 grip strength, tenderness to palpation, positive axial compression test, hyper-reflexic upper extremity deep tendon reflexes, and diminished sensation to light touch over the C5 and C6 dermatomes. Recommendations at that time included an EMG/NCV of the bilateral upper and lower extremities as well as aquatic therapy twice per week for 3 weeks. There was no Request for Authorization form submitted for this review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**EMG/NCV Bilateral Upper and Lower Extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178, Chronic Pain Treatment Guidelines Electromyography (EMG), and nerve conduction velocities (NCV).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 177-179, 303-305.

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state electromyography may be useful to identify subtle, focal neurological dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks. The guidelines further state electromyography and nerve conduction velocities may help identify focal neurologic dysfunction in patients with neck or arm symptoms lasting more than 3 or 4 weeks. While it is noted that the injured worker has exhausted conservative treatment in the form of heat/ice therapy and medications, there was no documentation of an attempt at recent conservative treatment in the form of active rehabilitation. Additionally, the injured worker has objective evidence of diminished sensation in the bilateral lower extremities, positive straight leg raising bilaterally, and absent deep tendon reflexes in the bilateral lower extremities. There was also objective evidence of positive axial compression test, hyper-reflexic upper extremity deep tendon reflexes, and decreased sensation in the C5 and C6 dermatomes. Given that there is objective evidence of cervical and lumbar radiculopathy upon examination, the medical necessity for electrodiagnostic studies has not been established in this case. Given the above, the request is not medically appropriate at this time.

**Aquatic Therapy 2 times a week for 3 weeks Cervical Spine:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22.

**Decision rationale:** The California MTUS Guidelines recommend aquatic therapy as an optional form of exercise therapy, where available, as an alternative to land based physical therapy. Aquatic therapy is specifically recommended where reduced weight bearing is desirable. There was no mention of a contraindication to land based physical therapy as opposed to aquatic therapy. There was no indication that this injured worker requires reduced weight bearing. Given the above, the request is not medically appropriate.