

Case Number:	CM15-0138862		
Date Assigned:	07/28/2015	Date of Injury:	04/27/2014
Decision Date:	08/25/2015	UR Denial Date:	07/13/2015
Priority:	Standard	Application Received:	07/17/2015

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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 35 year old male who sustained an industrial injury on April 27, 2014. He was breaking up a fight between several inmates and injured his left knee, right shoulder, and right wrist. He has reported left knee pain, right shoulder pain, lower back pain, right knee pain, and bilateral wrist pain and has been diagnosed with displacement of lumbar intervertebral disc without myelopathy, rotator cuff syndrome of shoulder and allied disorders, acute and sub-acute iridocyclitis unspecified, and left ACL tear. Treatment has included acupuncture, medical imaging, and medications. There was moderate tenderness in the left knee peripatellar area. There was positive mobility, Valgus, Varus, and McMurray's. There was moderate palpable tenderness to the right knee. There was positive mobility and valgus. There was tenderness to the right shoulder and left shoulder. There was tenderness to the right wrist with decreased range of motion. There was tenderness to the left wrist with decreased range of motion. The treatment plan included chiropractic care, physiotherapy, therapeutic exercise, NCV/EMG, and orthopedic surgical consultation. The treatment request included Chiropractic care, physiotherapy and therapeutic exercises x 8 visits and NCV/EMG testing.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic care, physiotherapy and therapeutic exercises; eight (8) visits: 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.

Decision rationale: The claimant sustained a work injury in April 2014 and is being treated for low back, bilateral knee, right shoulder, and bilateral wrist pain. Treatments have included 24 acupuncture sessions and an unknown number of chiropractic treatments. In April 2015, additional acupuncture treatment was requested because he was not improving as expected. A return to chiropractic care was planned after completion of 24 sessions. When seen in June 2015, there had been a decrease in pain and he was improving. Physical examination findings included multiple areas of tenderness with decreased range of motion. There was decreased grip strength with positive left Phalen's testing. EMG/NCS testing of the upper and lower extremities and continued chiropractic care was requested. Chiropractic care is recommended as an option in the treatment of chronic pain. Guidelines recommend a trial of 6 visits over 2 weeks with further treatment considered if there is objective evidence of functional improvement and with a total of up to 18 visits over 6-8 weeks. In this case, the number of total visits being requested is unknown and the duration of treatment provided is already in excess of that recommended. The request is not medically necessary.

EMG/NCV Testing: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Electrodiagnostic testing (EMG/NCS) and Other Medical Treatment Guidelines AANEM Recommended Policy for Electrodiagnostic Medicine.

Decision rationale: The claimant sustained a work injury in April 2014 and is being treated for low back, bilateral knee, right shoulder, and bilateral wrist pain. Treatments have included 24 acupuncture sessions and an unknown number of chiropractic treatments. In April 2015, additional acupuncture treatment was requested because he was not improving as expected. A return to chiropractic care was planned after completion of 24 sessions. When seen in June 2015, there had been a decrease in pain and he was improving. Physical examination findings included multiple areas of tenderness with decreased range of motion. There was decreased grip strength with positive left Phalen's testing. EMG/NCS testing of the upper and lower extremities and continued chiropractic care was requested. Electrodiagnostic testing (EMG/NCS) is generally accepted, well-established and widely used for localizing the source of neurological symptoms and establishing the diagnosis of focal nerve entrapments, such as carpal tunnel syndrome or radiculopathy. Criteria include that the testing be medically indicated. In this case, there is positive left Phalen testing with no other evidence of peripheral nerve compression and testing of all four extremities is being requested. There is no documented neurological examination that

would support the need for obtaining bilateral upper extremity EMG or NCS testing. This request is not medically necessary.