

<b>Case Number:</b>	CM15-0162919		
<b>Date Assigned:</b>	08/31/2015	<b>Date of Injury:</b>	05/12/2014
<b>Decision Date:</b>	10/07/2015	<b>UR Denial Date:</b>	08/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/19/2015

### 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

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 48 year old female, who sustained an industrial injury on 5-12-2014. She reported low back pain from a fall off-of a chair. Diagnoses include herniated nucleus pulposus of lumbar spine with right sided radiculopathy. Treatments to date include activity modification, NSAID, oral steroid, and therapeutic injections. Currently, she complained of low back pain with radiation to bilateral lower extremities. On 7-28-15, the physical examination documented restricted lumbar range of motion with tenderness and positive straight leg raise test bilaterally. There was decreased sensation of bilateral lower extremities noted. The plan of care included electromyogram and nerve conduction studies (EMG/NCS) of bilateral lower extremities and lumbar spine x-rays, AP-Lateral-Flexion.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**EMG/NCS Bilateral Lower Extremities:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back chapter, under EMGs-electromyography Low Back chapter, under Nerve conduction studies.

**Decision rationale:** The patient was injured on 05/12/14 and presents with low back pain and leg pain. The request is for an EMG/NCS Of The Bilateral Lower Extremities. The utilization review denial rationale is that there are "no findings consistent with radiculopathy." There is no RFA provided and the patient is working full time with modifications. There is no indication of any prior EMG/NCV studies the patient may have had of her lower extremities. ODG Guidelines, Low Back chapter, under EMGs, electromyography, ODG states, "Recommended as an option needle, not surface. EMGs may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious." ODG Guidelines, Low Back chapter, under Nerve conduction studies, NCS, states, "Not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy." ODG for Electrodiagnostic studies states, "NCS which are not recommended for low back conditions, and EMGs which are recommended as an option for low back." The patient is diagnosed with herniated nucleus pulposus of lumbar spine with right sided radiculopathy. Treatments to date include activity modification, NSAID, oral steroid, and therapeutic injections. The reason for the request is not provided and there is no indication that a prior EMG/NCV testing has been done. Given the patient's continued complaints of pain with radicular components, further diagnostic testing may be useful to obtain unequivocal evidence of radiculopathy. The requested EMG/NCV is medically necessary.

**Acupuncture:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment 2007.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment 2007.

**Decision rationale:** The patient was injured on 05/12/14 and presents with low back pain and leg pain. The request is for Acupuncture (quantity not indicated). There is no RFA provided and the patient is working full time with modifications. Review of the reports provided does not indicate if the patient had any prior acupuncture sessions. MTUS Guidelines, Acupuncture, page 8 recommends acupuncture for pain, suffering, and for restoration of function. Recommended frequency and duration is 3 to 6 treatments for trial, and with functional improvement, 1 to 2 per month. For additional treatment, MTUS Guidelines require functional improvement as defined by Labor Code 9792.20(e), A significant improvement in ADLs, or change in work status and reduced dependence on medical treatments. The patient is diagnosed with herniated nucleus pulposus of lumbar spine with right sided radiculopathy. Treatments to date include activity modification, NSAID, oral steroid, and therapeutic injections. There is no indication of any prior acupuncture sessions the patient may have had. In this case, acupuncture cannot be warranted without knowing the requested duration and frequency of the acupuncture. MTUS Guidelines for acupuncture are based on the number of acupuncture sessions. Without specifying the total number of sessions, or duration and frequency of sessions, the request cannot be verified to be in

accordance with MTUS Guidelines. Therefore, the requested acupuncture is not medically necessary.

**X-ray LS Spine AP/Lateral/Flexion:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back-Lumbar & Thoracic Chapter, under Flexion/Extension Imaging Studies.

**Decision rationale:** The patient was injured on 05/12/14 and presents with low back pain and leg pain. The request is for X-Ray Ls Spine Ap/Lateral/Flexion. There is no RFA provided and the patient is working full time with modifications. Review of the reports provided does not indicate if the patient had any prior x-ray of the lumbar spine. ODG Guidelines, Low Back-Lumbar & Thoracic Chapter, under Flexion/Extension Imaging Studies, state the following: Not recommended as a primary criteria for range of motion. An inclinometer is the preferred device for obtaining accurate, reproducible measurements. See Range of motion (ROM); Flexibility. For spinal instability, may be a criteria prior to fusion, for example in evaluating symptomatic spondylolisthesis when there is consideration for surgery. MTUS/ACOEM Practice Guidelines, 2nd Edition (2004), page 303-305, Chapter 12 "Low Back Complaints" under Special Studies and Diagnostic and Treatment Considerations states: "Lumbar spine x rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks." The patient has a limited lumbar spine flexion/extension and a positive straight leg raise. She is diagnosed with herniated nucleus pulposus of lumbar spine with right sided radiculopathy. Treatments to date include activity modification, NSAID, oral steroid, and therapeutic injections. In this case, there is no discussion regarding evaluation of symptomatic spondylolisthesis, lumbar instability and impending fusion surgery, as required by ODG for flexion/extension x-rays. Therefore, the request is not medically necessary.

**Chiropractic:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

**Decision rationale:** The patient was injured on 05/12/14 and presents with low back pain and leg pain. The request is for Chiropractic (quantity not indicated). There is no RFA provided and the patient is working full time with modifications. Review of the reports provided does not indicate if the patient had any prior chiropractic sessions. MTUS Guidelines, Manual Therapy & Manipulation, pages 58-59 allow up to 18 sessions of treatment following initial trial of 3 to 6 if functional improvements can be documented. The patient is diagnosed with herniated nucleus pulposus of lumbar spine with right sided radiculopathy. Treatments to date include activity

modification, NSAID, oral steroid, and therapeutic injections. There is no indication of any prior chiropractic sessions the patient may have had. In this case, chiropractic care cannot be warranted without knowing the requested duration and frequency. MTUS Guidelines for chiropractic care are based on the number of chiropractic sessions. Without specifying the total number of sessions, or duration and frequency of sessions, the request cannot be verified to be in accordance with MTUS Guidelines. Therefore, the requested chiropractic care is not medically necessary.