MAXIMUS Federal Services

| Case Number: | CM15-0163445 | | |
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| Date Assigned: | 08/31/2015 | Date of Injury: | 02/11/2015 |
| Decision Date: | 09/30/2015 | UR Denial Date: | 08/12/2015 |
| Priority: | Standard | Application Received: | 08/20/2015 |

## 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: Arizona, California
Certification(s)/Specialty: Family Practice

## CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This injured worker is a 55 year old female who reported an industrial injury on 2-11-2015. Her diagnoses, and or impressions, were noted to include: cervical sprain-strain with disc disease and radiculitis; left lateral epicondylitis; lumbar sprain-strain; lumbar facet joint disease; and headaches. No current imaging studies were noted. Her treatments were noted to include: physical therapy; diagnostic x-rays; an attempt at electrophysiological studies on 4-7-2015 which were aborted due to the inability to tolerate the stimulation; medication management; and modified work duties. The progress notes of 6-5-2015 reported constant, moderate-severe neck pain, left > right, that radiated into her arms, left > right, with numbness, tingling and electric shock-like sensations in the left upper extremity which was aggravated by activity; and of non-radiating low back pain with stiffness. Objective findings were noted to include: no acute distress; tenderness along the cervical para-spinal muscles and facet joints, left > right; decreased cervical range-of-motion; positive left Spruling's test; decreased left brachioradialis deep tendon reflexes; decreased sensation to the left upper extremity; tenderness over the left lateral epicondyle; and tenderness with decreased range-of-motion in the lumbar para-spinal muscles and facet joints. The physician's requests for treatments were noted to include chiropractic treatments and electromyogram with nerve conduction velocity studies of the bilateral upper extremities.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic treatment 2x/week for 6 weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-59.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy Page(s): 58.

**Decision rationale:** According to the MTUS guidelines, Chiropractic therapy is considered manual therapy. It is recommended for chronic musculoskeletal pain. For Low back pain, therapeutic care is for 6 visits over 2 weeks with functional improvement up to a maximum of 18 visits over 8 weeks. In this case, the claimant had completed numerous sessions of physical therapy. The therapeutic benefit of the modalities was not specified and response from the last 6 sessions is unknown to warrant 12 sessions. As a result additional chiropractor therapy is not necessary.

**EMG/ NCV for the bilateral upper extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 265.

**Decision rationale:** According to the guidelines, an EMG is recommended to clarify nerve root dysfunction in cases of suspected disk herniation preopereratvely or before epidural injection. It is not recommended for the diagnoses of nerve root involvement if history and physical exam, and imaging are consistent. An NCV is not recommended to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but recommended if the EMG is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely based on the clinical exam. In this case, althought there are abnormalities in the neurological exam, the physician requested an MRI of the cervical spine as well. Results are unknown. Therefore, the EMG/NCV is not warranted at this to differentiate and discrepancy in findings. The request is therefore not medically necessary.