

<b>Case Number:</b>	CM15-0180460		
<b>Date Assigned:</b>	09/22/2015	<b>Date of Injury:</b>	12/27/2006
<b>Decision Date:</b>	11/25/2015	<b>UR Denial Date:</b>	09/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/15/2015

### 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: New York  
 Certification(s)/Specialty: Pediatrics, Internal Medicine

### 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 55 year old female, who sustained an industrial injury on December 27, 2006. On August 13, 2015 the injured worker reported persistent neck pain which she rated 5-6 on a 10-point scale "which is the same but slightly worsening in the upper extremities with weakness and numbness." She reported she is dropping things with the left arm which is worse than the right. Her low back pain is rated 5-6 on a 10-point scale "which is the same radiating down both legs." She reported left shoulder pain which she rated a 5-6 on a 10-point scale and bilateral knee pain which she rated a 7 on a 10-point scale. She reported worsening bilateral knee symptoms with swelling. She reported persistent headaches and blurry vision secondary to neck pain. Her Naproxen helped reduce her pain from a 6 to a 3 and her Norco helped reduce her pain from a 6-7 to a 2-3 on a 10-point scale. The injured worker was working. On physical examination she had decreased cervical spine range of motion with flexion to 50 degrees, extension to 45 degrees, right rotation to 70 degrees, left rotation to 60 degrees, right lateral flexion to 30 degrees and left lateral flexion to 35 degrees. She had tenderness to palpation over the suboccipital region and cervical paraspinal muscles with bilateral hypertonicity. A cervical compression test was positive. She had normal sensation in C5, C6, and C7 nerve distributions bilaterally. She had decreased range of motion of the lumbar spine with flexion to 40 degrees, extension to 20 degrees, right lateral flexion to 15 degrees, and left lateral flexion to 20 degrees. She had tenderness to palpation of the lumbar paraspinals and gluteal muscles with bilateral hypertonicity. She has positive straight leg raise and Kemp's tests bilaterally. The injured worker was unable to heel-toe walk bilaterally. Her sensation was normal on the right and decreased on

the left in the L5 and S1 nerve distributions. She had decreased range of motion of the left knee with flexion to 130 degrees and extension to 0 degrees. There was tenderness to palpation over the medial joint line and popliteal fossa. Muscle strength was 4-5 with flexion and 5-5 with extension. Treatment included lumbar fusion, left knee arthroscopy, physical therapy, NSAIDS, and pain medications. The injured worker was diagnosed as having chronic cervical strain, lumbar disc herniation, status post lumbar fusion, persistent low back pain with radiculopathy of the bilateral lower extremities, and left knee meniscal tear. A request for authorization for MRI of the lumbar spine, MRI of the cervical spine, EMG-NCV of the bilateral upper extremities and the bilateral lower extremities, and massage therapy for the lumbar spine and left knee two times six was received on August 27, 2015. On September 3, 2015, the Utilization Review physician determined MRI of the lumbar spine, MRI of the cervical spine, EMG-NCV of the bilateral upper extremities and the bilateral lower extremities was not medically necessary and modified massage therapy for the lumbar spine and left knee two times six to massage therapy x 6 sessions to the back and knee.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **MRI (magnetic resonance imaging), Lumbar spine, with and without contrast: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back - MRI (magnetic resonance imaging).

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

**Decision rationale:** ACOEM addresses initial imaging studies not reimaging after prolonged symptoms. ODG states that repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation). The IW has continued symptoms with complaints low back pain with radiation down the legs and stable neurologic findings. Lumbar MRI is not medically necessary and appropriate.

#### **MRI (magnetic resonance imaging), Cervical spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines: Neck & Upper Back - MRI (magnetic resonance imaging).

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies.

**Decision rationale:** Per ACOEM neck chapter imaging is recommended in the following circumstances, an imaging study may be appropriate for a patient whose limitations due to consistent symptoms have persisted for four to six weeks or more, when surgery is being

considered for a specific anatomic defect and to further evaluate the possibility of potentially serious pathology, such as a tumor. The included physical examination does not document significant neurologic dysfunction. The request is not medically necessary.

**EMG (electromyography)/ NCV (nerve conduction velocity), Bilateral Lower Extremities:**  
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 rationale:** According to MTUS guidelines electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. MTUS does not have recommendations regarding NCS. ODG states that EMG is recommended as an option (needle, not surface). EMGs (electromyography) 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 states that NCS is not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Due to the request being for both studies and longstanding left L5 - S1 radiculopathy the request is considered not medically reasonable and necessary.

**EMG (electromyography)/ NCV (nerve conduction velocity), Bilateral Upper Extremities:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies.

**Decision rationale:** Per ODG guidelines EMG is recommended (needle, not surface) as an option in selected cases While cervical electrodiagnostic studies are not necessary to demonstrate a cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality or some problem other than a cervical radiculopathy, but these studies can result in unnecessary over treatment. As per the documentation, the IW had reports of numbness and tingling down both arms but there were no neurologic deficits on examination. The EMG is not medically necessary and appropriate.

**Massage therapy, Lumbar Spine & Left Knee, 2 times wkly for 6 wks, 12 sessions:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Low Back - Lumbar & Thoracic, Knee & Leg - Massage therapy.

**Decision rationale:** Per ODG guidelines massage for the low back is recommended as an option in conjunction with recommended exercise programs. Manual massage administered by professional providers has shown some proven efficacy in the treatment of acute low back symptoms, based on quality studies. Mechanical massage devices are not recommended. ODGs recommended frequency and duration of treatment for massage therapy are the same as Manipulation: Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Per ODG guidelines massage for the knee is recommended as an option for osteoarthritis (OA). Massage therapy seems to be efficacious in the treatment of OA of the knee Recommend massage use in conjunction with exercise, and limiting treatment to 8 visits (similar to PT). Although the massage treatment is recommended the request exceeds the recommended trial frequency. The request is not medically necessary and appropriate.