

<b>Case Number:</b>	CM15-0183064		
<b>Date Assigned:</b>	09/23/2015	<b>Date of Injury:</b>	09/25/2014
<b>Decision Date:</b>	11/18/2015	<b>UR Denial Date:</b>	09/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/17/2015

### 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: California

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 38 year old male, who sustained an industrial injury on September 25, 2014, incurring left shoulder, mid and lower back injuries. He was diagnosed with a closed fracture of the thoracic vertebra, compression fracture of the lumbosacral spine, cervical spine strain, and thoracic spine strain. Treatment included muscle relaxants, pain medications, anti-inflammatory drugs, physical therapy and home exercise program, chiropractic sessions, activity restrictions and modifications. Currently, the injured worker complained of low back pain with persistent low back muscle spasms. He rated his pain 7 out of 10 on a pain scale of 1 to 10. He was noted to have decreased range of motion of the lower back with loss of strength upon movement. The injured worker developed frequent headaches, anxiety and depression loss of sleep and sexual dysfunction as a result of chronic pain. The treatment plan that was requested for authorization on September 17, 2015, included Electromyography for the bilateral upper extremities, Magnetic Resonance Imaging of the thoracic spine, pain management, orthopedic consultation, twelve chiropractic treatments and twelve physical therapy treatments. Notes indicate that the patient has previously undergone a thoracic MRI. On September 10, 2015, a request for Electromyography studies, Magnetic Resonance Imaging of the thoracic spine, pain management, orthopedic consultation, chiropractic sessions, and physical therapy treatments was denied by utilization review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**EMG bilateral upper extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back Chapter.

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck Chapter, Electrodiagnostic Studies, Electromyography, Nerve Conduction Studies.

**Decision rationale:** Regarding the request for EMG of bilateral upper extremities, Occupational Medicine Practice Guidelines state that the electromyography and nerve conduction velocities including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. Guidelines go on to state that EMG is recommended to clarify nerve root dysfunction if findings of history and physical exam are consistent. Within the documentation available for review, there are no recent subjective complaints or physical examination findings identifying subtle focal neurologic deficits in a radicular distribution. In the absence of such documentation, the currently requested EMG of bilateral upper extremities is not medically necessary.

**MRI of the thoracic spine:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck Chapter, MRI.

**Decision rationale:** Regarding the request for repeat thoracic MRI, guidelines support the use of imaging for emergence of a red flag, physiologic evidence of tissue insult or neurologic deficit, failure to progress in a strengthening program intended to avoid surgery, and for clarification of the anatomy prior to an invasive procedure. Guidelines also recommend MRI after 3 months of conservative treatment. ODG states that repeat MRI is not routinely recommended in less there is a significant change in symptoms and or findings suggestive of significant pathology. Within the documentation available for review, there is no indication of any red flag diagnoses. Additionally there is no recent documentation of neurologic deficit in the upper extremities or chest wall. Finally, there is no documentation of changed subjective complaints or objective findings since the time of the most recent thoracic MRI. In the absence of such documentation the requested thoracic MRI is not medically necessary.

**Pain management:** Upheld

**Claims Administrator guideline:** Decision based on MTUS General Approaches 2004, Section(s): Cornerstones of Disability Prevention and Management.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation x American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Occupational Medicine Practice Guidelines, Independent Medical Examinations and Consultations Chapter, Page 127, Other Medical Treatment Guideline or Medical Evidence: State of Colorado, Chronic Pain Disorder Medical Treatment Guidelines, Exhibit Page Number 52.

**Decision rationale:** Regarding the request for referral to pain management for consultation, California MTUS does not address this issue. ACOEM supports consultation if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. Within the documentation available for review, the patient has ongoing pain corroborated by physical exam findings. However, it is unclear exactly why pain management consultation is being requested. The patient's current physician seems to feel comfortable treating the patient conservatively there is no discussion regarding any interventional treatments being sought. In light of the above issues, the currently requested referral to pain management for consultation is not medically necessary.

**Ortho consult:** Upheld

**Claims Administrator guideline:** Decision based on MTUS General Approaches 2004, Section(s): Cornerstones of Disability Prevention and Management.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation x American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Occupational Medicine Practice Guidelines, Independent Medical Examinations and Consultations Chapter, Page 127.

**Decision rationale:** Regarding the request for consultation, California MTUS does not address this issue. ACOEM supports consultation if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. Within the documentation available for review, the requesting physician has not identified any uncertain or extremely complex diagnoses or any concurrent psychosocial factors. Additionally, there is no documentation that the physician has tried to address these issues prior to considering a referral. Finally, there is no statement indicating why the patient is being referred to an orthopedic surgeon. In the absence of such documentation, the currently requested consultation is not medically necessary.

**Chiropractic treatment x 12:** 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:** Regarding the request for additional chiropractic care, Chronic Pain Medical Treatment Guidelines support the use of chiropractic care for the treatment of chronic pain caused by musculoskeletal conditions. Guidelines go on to recommend a trial of up to 6 visits over 2 weeks for the treatment of low back pain. With evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks may be supported. Within the documentation available for review, there is documentation of completion of prior chiropractic sessions, but there is no documentation of specific objective functional improvement with the previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. Furthermore, it is unclear how many therapy sessions the patient has already undergone making it impossible to determine if the patient has exceeded the maximum number recommended by guidelines for their diagnosis. In the absence of clarity regarding the above issues, the currently requested chiropractic care is not medically necessary.

**Physical therapy x 12:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Initial Care, Activity Alteration, and Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back Chapter, Physical Therapy.

**Decision rationale:** Regarding the request for additional physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is documentation of completion of prior PT sessions, but there is no documentation of specific objective functional improvement with the previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. Furthermore, it is unclear how many therapy sessions the patient has already undergone making it impossible to determine if the patient has exceeded the maximum number recommended by guidelines for their diagnosis. In light of the above issues, the currently requested additional physical therapy is not medically necessary.