

<b>Case Number:</b>	CM15-0198519		
<b>Date Assigned:</b>	10/14/2015	<b>Date of Injury:</b>	06/20/2014
<b>Decision Date:</b>	11/20/2015	<b>UR Denial Date:</b>	09/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/08/2015

### 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: Anesthesiology

### 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 42 year old female, who sustained an industrial injury on June 20, 2014. She reported that her pre-existing lower back problems became 100% worse. The injured worker was currently diagnosed as having lumbar radiculopathy, lumbar post-laminectomy syndrome, lumbar facet arthropathy and myofascial pain. On September 8, 2015, the injured worker complained of low back pain and constant left lower extremity radiculopathy. She stated that she did not have this radiculopathy before her surgery in 2013. Therapy was noted to help her temporarily. The injured worker started using a transcutaneous electrical nerve stimulation unit in July 2015. She stated that it did not help her and she would like the H-wave unit. On September 22, 2015, utilization review denied a request for an EMG of the lower extremity and chiropractic treatment for the lumbar spine at two times a week for six weeks. A request for physical therapy for the lumbar spine at two times a week for six weeks was modified to physical therapy six additional visits for the lumbar spine. A request for an H-wave unit was modified to an H-wave unit one month home-base trial (rental).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**EMG (Electromyelography) of LE (lower extremity): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines) Low Back (updated 04/29/15), Electrodiagnostic studies (EDS).

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

**Decision rationale:** There is no documentation provided necessitating EMG testing of the left lower extremity. According to the ODG, electromyography (EMG) and nerve conduction studies are an extension of the physical examination. They can be useful in adding in the diagnosis of peripheral nerve and muscle problems. This can include neuropathies, entrapment neuropathies, radiculopathies, and muscle disorders. According to ACOEM Guidelines, needle EMG and H-reflex tests to clarify nerve root dysfunction are recommended for the treatment of low back disorders. In this case, the medical records document radiculopathy in an L5-S1 distribution despite operative and non-operative treatment. There are no new signs or symptoms present. The guidelines state that EMGs are not necessary if radiculopathy is already clinically obvious. Medical necessity for the requested study has not been established. The requested study is not medically necessary.

**Physical therapy for the lumbar spine 2 times a week for 6 weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM) Practice Guidelines: Chapter 6, Pain, Suffering and the Restoration of Function page 114.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

**Decision rationale:** According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. Recommendations state that for most patients with more severe and sub-acute low back pain conditions, 8 to 12 visits over a period of 6 to 8 weeks is indicated as long as functional improvement and program progression are documented. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assisting devices. In this case, the patient has completed a total of 6 physical therapy sessions. There is no documentation indicating that he had a defined functional improvement in his condition. There is no specific indication for the requested additional PT sessions (2/week x 6 weeks). Medical necessity for the requested PT services has not been established. The requested services are not medically necessary.

**Chiropractic treatment for the lumbar spine 2 times a week for 6 weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004, and Chronic Pain Medical Treatment 2009.

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

**Decision rationale:** According to MTUS, Manual Therapy or Chiropractic therapy, is recommended for chronic pain if it is caused by musculoskeletal conditions. The intended goal or effect is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. For the treatment of low back pain, a trial of 6 visits is recommended over 2 weeks, with evidence of objective improvement, with a total of up to 18 visits over 6-8 weeks. If manipulation has not resulted in functional improvement in the first one or two weeks, it should be stopped and the patient reevaluated. In this case, the injured worker has radiculopathy. Chiropractic treatment is not recommended for patient with radicular pain. In addition, the medical records provided for review did not document objective functional improvement with prior chiropractic treatments. Medical necessity for the requested additional chiropractic sessions (2/week x 6 weeks) has not been established. The requested services are not medically necessary.

**H Wave unit:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) H-wave stimulation (devices), Pain Chapter.

**Decision rationale:** According to the CA MTUS Guidelines (2009), H-wave stimulation (HWT) is not recommended as an isolated intervention. A one-month home-based trial of HWT may be considered a noninvasive conservative option for diabetic neuropathic pain or chronic soft tissue inflammation, if used as an adjunct to a program of evidence-based functional restoration, and only following failure of initially recommended conservative care, including recommended physical therapy (i.e., exercise) and medications, plus transcutaneous electrical nerve stimulation (TENS). While H-Wave and other similar type devices can be useful for pain management, they are most successfully used as a tool in combination with functional improvement. H-wave stimulation is a form of electrical stimulation that differs from other forms of electrical stimulation, such as TENS, in terms of its waveform. H-wave stimulation is sometimes used for the treatment of pain related to a variety of etiologies, muscle sprains, temporomandibular joint dysfunctions or reflex sympathetic dystrophy. In fact, HWT is used more often for muscle spasm and acute pain as opposed to neuropathy or radicular pain. In this case, there is no documentation of objective functional improvement with the use of HWT. Medical necessity for the requested item has not been established. The requested HWT unit is not medically necessary.