

<b>Case Number:</b>	CM15-0020329		
<b>Date Assigned:</b>	02/09/2015	<b>Date of Injury:</b>	10/06/2014
<b>Decision Date:</b>	04/08/2015	<b>UR Denial Date:</b>	01/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/03/2015

### 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 Jersey, Michigan, California  
 Certification(s)/Specialty: Neurology, Neuromuscular 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 58 year old female who sustained a work related injury October 6, 2014 with low back pain due to cumulative trauma; repetitive driving, sitting, and getting in and out of vehicle. Past history included right knee surgery, patellar fracture. She was initially treated by her primary care physician with Norco and physical therapy and placed on light duty. According to a doctor's first report of occupational injury or illness dated November 24, 2014, the injured worker presented with low back pain radiating to the left lower extremity and left hip and left shoulder pain. Diagnoses included lumbar spine sprain/strain and left shoulder periscapular strain. X-rays dated November 24, 2014, reveal left lower extremity radiculitis and Grade I (unclear), L5 S1 with facet hypertrophy L5-S1 (report not present in medical record and current finding not completely legible to this reviewer). Treatment plan included additional x-rays, MRI, interferential stimulation unit, home exercise program, medication, and chiropractic treatment. According to utilization review dated January 14, 2015, the request for MRI lumbar spine is non-certified, citing MTUS ACOEM Guidelines. The request for EMG/NCV bilateral lower extremities is non-certified, citing MTUS ACOEM Guidelines. The request for Chiropractic treatment; (12) visits (3 x 4) is non-certified, citing ODG, MTUS Guidelines. The request for Interferential Stimulation Unit, home use is non-certified, citing ODG.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI of the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

**Decision rationale:** Regarding the indications for imaging in case of back pain, MTUS guidelines stated :”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. However, it may be appropriate when the physician believes it would aid in patient management. Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures).” Furthermore, and according to MTUS guidelines, MRI is the test of choice for patients with prior back surgery, fracture or tumors that may require surgery. The patient does not have any clear evidence of lumbar radiculopathy or nerve root compromise. There is no change of the clinical examination. There is no clear evidence of significant change of the clinical examination of the patient compared to previous examination. There is no change in the patient signs or symptoms suggestive of new pathology. Therefore, the request for MRI of the lumbar spine is not medically necessary.

**EMG/NCV of the bilateral lower extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

**Decision rationale:** According to MTUS guidelines (MTUS page 303 from ACOEM 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.” EMG has excellent ability to identify abnormalities related to disc protrusion (MTUS page 304 from ACOEM guidelines). According to MTUS guidelines, needle EMG study helps identify subtle neurological focal dysfunction in patients with neck and arm symptoms. “When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study Electromyography (EMG), and

nerve conduction velocities (NCV), 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.” (page 178). EMG is indicated to clarify nerve dysfunction in case of suspected disc herniation (page 182). EMG is useful to identify physiological insult and anatomical defect in case of neck pain (page 179). Although the patient developed low back pain, there is no clear evidence that the patient developed peripheral nerve dysfunction or nerve root dysfunction. MTUS guidelines does not recommend EMG/NCV without signs of radiculopathy or nerve dysfunction. Therefore, the request for EMG/NCV study of the bilateral lower extremities is not medically necessary.

**Chiropractic treatment 3 times a week for 4 weeks (12 visits): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation ODG Chiropractic Guidelines, Therapeutic Care.

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

**Decision rationale:** According to MTUS guidelines, “Recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine 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. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion.” “Low back: Recommended as an option. Therapeutic care- Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks.” There is no documentation of objective findings that support musculoskeletal dysfunction requiring more physical therapy including manual therapy. There is no rationale from using of 12 chiropractic visits without documentation of the efficacy of the first 3 or 4 visits. Therefore, Chiropractic treatment 3 times a week for 4 weeks (12 visits) is not medically necessary.

**Interferential Stim unit for home use: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain Chapter, Interferential Current Stimulation (ICS).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-119.

**Decision rationale:** According to MTUS guidelines, “Interferential Current Stimulation (ICS). Not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The

randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. (Van der Heijden, 1999) (Werner, 1999) (Hurley, 2001) (Hou, 2002) (Jarit, 2003) (Hurley, 2004) (CTAF, 2005) (Burch, 2008) The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and/or methodologic issues. While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway: Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: Pain is ineffectively controlled due to diminished effectiveness of medications; or Pain is ineffectively controlled with medications due to side effects; or History of substance abuse; or Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.)” There is no clear evidence that the patient did not respond to conservative therapies, or have post op pain that limit his ability to perform physical therapy. There is no clear evidence that the neurostimulator will be used as a part of a rehabilitation program. There is no evidence of left knee functional deficit that required neuro stimulator therapy. There is no documentation of the outcome of previous physical therapy and TENS. Therefore, the request for Interferential Stim unit for home use is not medically necessary.

**Lumbar Spine Orthosis:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

**Decision rationale:** According to MTUS guidelines, lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. A lumbar corset is recommended for prevention and not for treatment. Therefore, the request for Lumbar Spine Orthosis is not medically necessary.