MAXIMUS Federal Services

| Case Number: | CM15-0033299 | | |
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| Date Assigned: | 02/26/2015 | Date of Injury: | 07/27/2014 |
| Decision Date: | 05/15/2015 | UR Denial Date: | 02/02/2015 |
| Priority: | Standard | Application Received: | 02/23/2015 |

## 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 47-year-old female, who sustained an industrial injury on July 27, 2014. The injured worker had reported dizziness and pain in the spine. The diagnoses have included lumbar bulging discs, cervical sprain, lumbar radiculopathy, vertigo and enthesopathy of the hip. Treatment to date has included medication, physical therapy and acupuncture treatments. Current documentation dated January 20, 2015 notes that the injured worker complained of intermittent stiffness and cracking in the neck. She denies neck pain. She also reported mid back pain on the right side and sharp low back pain, which radiated to the bilateral lower extremities, more on the right. Associated symptoms included weakness and numbness in the heel and ankle. The injured worker also reported frequent dizzy spells. Physical examination of the cervical spine revealed tenderness to palpation of the paraspinal muscles, spasms and a restricted range of motion. Examination of the lumbar spine showed tenderness to palpation in the paraspinal muscles with spasms. Range of motion was restricted. On February 2, 2015 Utilization Review non-certified a request for chiropractic treatments three times a week for four weeks to the cervical, thoracic and lumbar spine, an electromyography/nerve conduction study of the bilateral lower extremities, electromyography/nerve conduction study of the upper extremities, MRI of the thoracic spine and Orphenadrine ER 100 mg # 60 with 2 refills. The MTUS, ACOEM Guidelines and the Official Disability Guidelines, were cited.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic Treatment three (3) times per week for four (4) weeks to Cervical/Thoracic/Lumbar:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-60.

**Decision rationale:** Per MTUS guidelines chiropractic care is recommended for chronic pain if caused by musculoskeletal conditions. Guidelines recommend an initial trial of 6-12 visits over a 2-4 week period, and, at the midway point as well as at the end of the trial, there should be a formal assessment whether the treatment is continuing to produce satisfactory clinical gains. This request is medically necessary and appropriate.

**EMG/NCS Bilateral Upper Extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck & Upper Back Chapter, Electromyography and Nerve Conduction Studies.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck Chapter.

**Decision rationale:** Per ODG guidelines EMG is recommended (needle, not surface) as an option in selected cases While cervical electro-diagnostic 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. Due to the concern for false positive EMG given the lack of neurologic findings, the EMG is not medically necessary and appropriate.

**EMG/NCS Bilateral Lower Extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter, EMGs (Electromyography) and Nerve Conduction Studies (NCS).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter.

**Decision rationale:** EMG's (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 4-8 weeks conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. There is no clear description of a radiculopathy, the

IW describes shooting pain however, it is not described as dermatomal in pattern nor are there clinical sensory findings. This request is not medically necessary and appropriate.

**MRI of the Thoracic Spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, MRIs (magnetic resonance imaging).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter.

**Decision rationale:** Per ODG guidelines MRI's are test of choice for patients with prior back surgery, but for uncomplicated low back pain, with radiculopathy, not recommended until after at least one month conservative therapy, sooner if severe or progressive neurologic deficit. Per the included documentation, the IW did not have a history of back surgery and the radiating pain was not documented to follow a dermatomal pattern. The request is not medically necessary and appropriate.

**Orphenadrine ER 100mg #60 with 2 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-65.

**Decision rationale:** MTUS recommends non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. It is noted that in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. The IW is noted to be on an NSAID and that the muscle relaxant is a new addition for treatment of chronic low back pain without acute exacerbation. The request is not medically necessary and appropriate.