

<b>Case Number:</b>	CM14-0162346		
<b>Date Assigned:</b>	10/07/2014	<b>Date of Injury:</b>	02/22/2012
<b>Decision Date:</b>	11/07/2014	<b>UR Denial Date:</b>	09/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/02/2014

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 46-year-old female who reported an injury on 02/22/2012. The mechanism of injury was not submitted for review. The injured worker has diagnoses of left shoulder injury, status post left shoulder surgery, displacement of cervical intervertebral disc without myelopathy and cervical radiculitis. Past medical treatment consists of chiropractic therapy, acupuncture therapy, physical therapy, medication therapy, as well as steroid and Toradol injections. There were no diagnostics submitted for review. On 09/10/2014, the injured worker complained of shoulder and neck pain. It was noted on physical examination that the injured worker had tenderness to palpation. There was decreased range of motion on the cervical spine and left shoulder. Medical treatment plan is for the injured worker to undergo an EMG/NCV of bilateral upper extremities, have use of a back brace and continue the use of chiropractic therapy with an additional 6 sessions. The rationale and Request for Authorization form were not submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**EMG/NCV bilateral upper extremity:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179..

**Decision rationale:** The request for EMG/NCV bilateral upper extremity is not medically necessary. The California MTUS/ACOEM Guidelines state that electromyography and nerve conduction velocities, including H-reflex test, may help identify subtle, focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than 3 to 4 weeks. The included medical documentation noted cervical pain. However, there was lack of neurologic deficits pertaining to the cervical spine documented on the physical examination. There was also a lack of evidence of a positive Spurling's test, decreased reflex, decreased strength, or decreased sensation. An adequate examination of the injured worker was not provided, detailing current deficits to warrant an EMG/NCV of the upper extremity. Given the above, the injured worker is not within recommended guidelines. As such, the request is not medically necessary.

**Back brace:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308.

**Decision rationale:** The request for Back brace is not medically necessary. The California MTUS/ACOEM Guidelines state because evidence is insufficient to support using vertebral axial decompression for treating low back injuries, it is not recommended. There is no medical indication that a back brace would assist in the treatment of the injured worker. Additionally, the provider did not submit a rationale as to how a back brace would benefit the injured worker with any functional deficits. As such, the request for a Back brace is not medically necessary.

**Chiropractic therapy 6 sessions; neck:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Chiropractic Page(s): 58.

**Decision rationale:** The request for Chiropractic therapy 6 sessions; neck is not medically necessary. The California MTUS Guidelines state chiropractic care for chronic pain is caused by musculoskeletal conditions is recommended. 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. The guidelines recommend a trial of 6 visits over 2 weeks, and with evidence of subjective functional improvement, a total of up to 18 visits over 6 to 8 weeks. The submitted documentation lack any indication of the outcome of the injured worker's previous chiropractic session. Additionally, there was no indication as to how many sessions of

chiropractic therapy the injured worker had completed to date. Given the above, the injured worker is not within the MTUS recommended Guidelines. As such, the request is not medically necessary.