

<b>Case Number:</b>	CM15-0115315		
<b>Date Assigned:</b>	06/23/2015	<b>Date of Injury:</b>	10/16/2014
<b>Decision Date:</b>	08/31/2015	<b>UR Denial Date:</b>	05/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/15/2015

### 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

### 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 with an industrial injury dated 10/16/2014. The mechanism of injury is documented as a fall with an 80 pound television falling onto her head, neck and shoulders. Her diagnoses included cervicgia and backache. Prior treatments included pain medications, anti-inflammatory medications, chiropractic (no significant pain relief), diagnostics and physical therapy (no significant relief.) She had failed Tizanidine and Naproxen due to limited efficacy. She presents on 03/26/2015 with pain from neck down to left arm and left hip down leg with numbness and tingling in left foot. She also noted inflammation in her neck had decreased. She rated her pain with medications as 9/10 and without medications 10/10. She did not report any change in location of pain and activity level remained the same. Quality of sleep was fair. She was taking medications as prescribed and stated they were working well. No side effects reported. Physical exam of the cervical spine noted spasm, tenderness and tight muscle band on both sides. There was spasm and tenderness of the lumbar spine with straight leg raising test positive on the left side and in supine position. Waddell's sign was negative. The treatment plan consisted of NCS/EMG studies of the left upper and left lower extremity, MRI of the lumbar spine, physical therapy of the cervical and lumbar spine and Celebrex. She was currently taking Celebrex and noted significant relief. An ergonomic work station was recommended and she was placed on modified duty. The treatment request is for EMG/NCS of left upper extremity, EMG/NCS of the left lower extremity, Lumbar spine MRI non-contrast and physical therapy 2 times a week for 6 weeks, lumbar and cervical.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**EMG/NCS of left upper extremity:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260-262.

**Decision rationale:** ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8, Neck and Upper Back Complaints, Special Studies and Diagnostic and Treatment Considerations, page 178 states: "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". ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11, page 260-262 states: "Appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful. NCS and EMG may confirm the diagnosis of CTS but may be normal in early or mild cases of CTS. If the EDS are negative, tests may be repeated later in the course of treatment if symptoms persist". According to progress report 03/26/2015, the patient presents with pain in the neck down to the left arm, and pain in the lower back and left hip down the left leg with numbness and tingling in left foot. Physical examination of the cervical spine noted spasm, tenderness and tight muscle band on both sides. There was spasm and tenderness of the lumbar spine with positive straight leg raising test on the left side in supine position. The treater would like to evaluate for cervical radiculopathy, and has requested an EMG/NCS of the left upper extremity. The patient's medical history included an MRI of the cervical spine in 2014, but no indication of prior EMG/NCV. ACOEM guidelines recommend electrodiagnostic studies to help differentiate between CTS and other conditions such as cervical radiculopathy. Given the patient's left upper extremity complaints, an EMG/NCV study may help the treater pinpoint the cause and location of the patient's symptoms. The request is in accordance with guidelines. Therefore, the request is medically necessary.

**EMG/NCS of the left lower extremity:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management, Chapter 12 Low Back Complaints Page(s): 79.

**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, under Nerve conduction studies.

**Decision rationale:** This patient presents with neck and lower back pain. The current request is for EMG/NCS of left lower extremity. The RFA is dated 04/02/15. Prior treatments included pain medications, anti-inflammatory medications, chiropractic treatments, diagnostics and physical therapy. The patient is to remain on modified duty. For EMG, ACOEM Guidelines Chapter 12 page 303 states "Electromyography, including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks." Regarding Nerve conduction studies, ODG guidelines Low Back Chapter, under Nerve conduction studies states, "Not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy". ODG guidelines Low Back Chapter for Electrodiagnostic studies (EDS) states, "(NCS) which are not recommended for low back conditions, and EMGs (Electromyography) which are recommended as an option for low back". According to progress report 03/26/2015, the patient presents with pain in the neck down to the left arm, and pain in the lower back and left hip down the left leg with numbness and tingling in left foot. Physical examination of the cervical spine noted spasm, tenderness and tight muscle band on both sides. There was spasm and tenderness of the lumbar spine with positive straight leg raising test on the left side in supine position. The treater would like evaluate for "lumbar radiculopathy or to evaluate for peripheral nerve entrapment," and has requested an EMG/NCS of the left lower extremity. In this case, given the patient's continued complaints of radiating pain into the lower extremity and positive SLR, further diagnostic testing may be useful to obtain unequivocal evidence of radiculopathy. There is no indication that prior EMG/NCV of the lower extremity has been done. Therefore, the request for EMG/NCV of the left lower extremities is medically necessary.

**Physical therapy 2 times a week for 6 weeks, lumbar and cervical:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98, 99.

**Decision rationale:** This patient presents with neck and lower back pain. The current request is for Physical therapy 2 times a week for 6 weeks, lumbar and cervical. The RFA is dated 04/02/15. Prior treatments included pain medications, anti-inflammatory medications, chiropractic treatments, diagnostics and physical therapy. The patient is to remain on modified duty. The MTUS Chronic Pain Management Guidelines, pages 98, 99 has the following: "Physical Medicine: recommended as indicated below. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine". MTUS guidelines pages 98, 99 states that for "Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis, and radiculitis, 8-10 visits are recommended." Per report 04/23/15, the patient has participated in "four sessions of physical therapy from October to November 2014". Per report 06/18/15, the patient "previously had around 4 visits of physical therapy which was very passive, primarily focusing on ultrasound". This patient needs a full course of active physical therapy for stretching, strengthening, modalities as indicated". Given the previous 4 sessions, additional 5-6 sessions may be

indicated. The requested additional 12 sessions in addition to those already completed exceeds MTUS guidelines and cannot be substantiated. The request is not medically necessary.

**Lumbar spine MRI non-contrast:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back chapter under MRI.

**Decision rationale:** This patient presents with neck and lower back pain. The current request is for Lumbar spine MRI non-contrast. The RFA is dated 04/02/15. Prior treatments included pain medications, anti-inflammatory medications, chiropractic treatments, diagnostics and physical therapy. The patient is to remain on modified duty. For special diagnostics, ACOEM Guidelines Chapter 12 page 303 states, "Unequivocal and equivocal objective findings that identify specific nerve compromise on neurological examination are sufficient evidence to warrant imaging in patients who do not respond well to treatment and who could consider surgery an option. Neurological examination is less clear; however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study". ODG Guidelines under the low back chapter regarding MRI states that "MRIs are test of choice for patients with prior back surgery, but for uncomplicated low back pain with radiculopathy, not recommended until at least 1 month of conservative therapy, sooner if severe or progressive neurologic deficit. Repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology, such as a tumor, infection, fracture, nerve compromise, recurrent disk herniation." According to progress report 03/26/2015, the patient presents with pain in the neck down to the left arm, and pain in the lower back and left hip down the left leg with numbness and tingling in left foot. Physical examination of the cervical spine noted spasm, tenderness and tight muscle band on both sides. There was spasm and tenderness of the lumbar spine with positive straight leg raising test on the left side in supine position. The treater would like to obtain an MRI of the lumbar spine to investigate "possible herniation/ radiculopathy". The medical records indicate that the patient had an MRI of cervical spine in 2014, but there is no indication of prior diagnostics of the lumbar spine. This patient has managed his lower back pain with conservative care including medications and physical therapy. The patient continues to have neurological deficits and an MRI for further investigation at this junction is supported by ACOEM and ODG guidelines. This request is medically necessary.