

<b>Case Number:</b>	CM15-0168146		
<b>Date Assigned:</b>	09/11/2015	<b>Date of Injury:</b>	03/22/2006
<b>Decision Date:</b>	11/09/2015	<b>UR Denial Date:</b>	08/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/26/2015

### 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 53 year old female, who sustained an industrial injury on 3-22-2006. The mechanism of injury was not provided. The injured worker was diagnosed as having cervical and lumbar sprain-strain, cervical and lumbar disc protrusion and bilateral wrist and knee sprain- strain. A recent progress report dated 7-28-2015, reported the injured worker complained of moderated neck and low back pain and bilateral wrist pain-right greater than left. Physical examination revealed palpable cervical and lumbar tenderness and in bilateral wrists and "decreased range of motion" in the cervical and lumbar spine and bilateral wrists. Radiology studies were not provided. Treatment to date has included physical therapy and medication management. On 7-28-2015, the Request for Authorization requested cervical and lumbar magnetic resonance imaging, electromyography (EMG) and nerve conduction study (NCS) of bilateral upper extremities and bilateral lower extremities, pain management consultation, physical therapy to the lumbar and cervical spine and bilateral wrists and knees and a right wrist brace. On 8-11-2015 the Utilization Review non-certified cervical spine magnetic resonance imaging and lumbar magnetic resonance imaging due to recent studies in January of 2015 and no progression of symptoms. The electromyography (EMG) -nerve conduction study (NCS) of the bilateral upper extremities, electromyography (EMG) -nerve conduction study (NCS) of the bilateral lower extremities, were noncertified due to lack of objective documentation. Pain management consultation-treatment was noncertified due to repeat pain management consultation was not justified. Physical therapy to the lumbar, cervical spine, bilateral wrists and bilateral knees was noncertified due to lack of documentation of prior therapy efficacy. Right wrist brace was noncertified due to lack of documentation to support the need.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **MRI Scan of the Cervical Spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back Chapter, Online Version, Magnetic Resonance Imaging.

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Diagnostic Criteria.

**Decision rationale:** According to CA MTUS/ACOEM guidelines, a cervical MRI is indicated if unequivocal findings identify specific nerve compromise on the neurologic examination, in patients who do not respond to conservative treatment, and who would consider surgical intervention. Cervical MRI is the mainstay in the evaluation of myelopathy. Per the ODG, MRI should be reserved for patients who have clear-cut neurologic findings and those suspected of ligamentous instability. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. In this case, the documentation indicates that the patient had a previous cervical MRI in January 2015, which did not reveal nerve impingement. There are no new neurologic findings on physical exam to warrant another MRI study. Medical necessity for the requested service is not established. The requested service is not medically necessary.

### **MRI Scan of the Lumbar Spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter, MRIs.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Diagnostic Criteria.

**Decision rationale:** According to California MTUS Guidelines, MRI of the lumbar spine is recommended to evaluate for evidence of cauda equina, tumor, infection, or fracture when plain films are negative and neurologic abnormalities are present on physical exam. In this case, there is no indication or rationale for an MRI of the lumbar spine. There are no subjective complaints of increased back pain, radiculopathy, bowel or bladder incontinence, and there are no new neurologic findings on physical exam. Therefore, medical necessity for the requested MRI has not been established. The requested imaging study is not medically necessary. In this case, the documentation indicates that the patient had a previous MRI of the lumbar spine in January 2015, which did not reveal nerve impingement. There are no new neurologic findings on physical exam to warrant another MRI study. Medical necessity for the requested service is not established. The requested service is not medically necessary.

### **EMG/NCS of the Bilateral Lower Extremities: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition, Update to Chapter 12, Low Back Disorders.

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

**Decision rationale:** There is no documentation provided necessitating EMG testing of both lower extremities. 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. According to the ODG, EMGs may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. In this case, there were no objective physical exam findings provided in the records to support repeat studies at this time. Medical necessity for the requested studies has not been established. The requested studies are not medically necessary.

### **EMG/NCS of the Bilateral Upper Extremities: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004.

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

**Decision rationale:** The request for diagnostic test EMG/NCV for bilateral upper extremities is not medically necessary. The California MTUS/ACOEM Guidelines state that electromyography and nerve conduction velocities, including H-reflex tests, may help identify subtle, focal neurologic dysfunction in patients with neck or arm problems, or both, lasting more than 3 to 4 weeks. The ODG further states that nerve conduction studies are recommended if the EMG is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely based on the clinical exam. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy.

**Pain Management Consultation/Treatment: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, Chapter 7, Independent Medical Examinations and Consultations.

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Initial Assessment, and Low Back Complaints 2004, Section(s): Initial Assessment.

**Decision rationale:** According to the ACOEM guidelines, a consultation is indicated to aid in the diagnosis, prognosis, and therapeutic management, determination of medical stability, and permanent residual loss and/or, the injured worker's fitness to return to work. In this case, there is no specific rationale identifying the medical necessity of the requested Pain Management consultation. There is no documentation that diagnostic and therapeutic management has been exhausted within the present treating provider's scope of practice. Medical necessity for the requested service has not been established. The requested service is not medically necessary.

**Physical Therapy Evaluation to Lumbar Spine, Cervical Spine, Bilateral Wrist, Bilateral Knee: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy.

**Decision rationale:** According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. 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. In this case, there is documentation indicating that the patient completed physical therapy however, the number of sessions completed and a detailed response to therapy was not provided. Medical necessity for the requested physical therapy sessions is not established. The requested physical therapy sessions are not medically necessary.

**Right Wrist Brace: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004.

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

**Decision rationale:** The ODG states that wrist splints are recommended for treating displaced fractures. Immobilization is standard for fracture healing although patient satisfaction is higher

with splinting rather than casting. Splints used for prolonged immobilization should be robust enough for everyday use, and of the central importance of patient adherence to instructions for splint use. in this case, a replacement splint has been requested but there is no documentation that the patient's current wrist splint is non-functional and there are no objective findings to support the need for a wrist brace. Medical necessity for the requested wrist brace has not been established. The requested wrist brace is not medically necessary.