

Case Number:	CM13-0016165		
Date Assigned:	12/11/2013	Date of Injury:	05/13/2010
Decision Date:	01/27/2014	UR Denial Date:	08/13/2013
Priority:	Standard	Application Received:	08/26/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician 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 physician 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:

This 46 year-old female Supervisor/Senior clerk typist sustained a cumulative upper extremity trauma on 5/13/10 while employed by the [REDACTED]. She is s/p anterior cervical discectomy and fusion of C5-7 in September 2012. The physical medicine and rehabilitation and electrodiagnostic consultative report dated 7/25/13 by [REDACTED] noted history of repetitive injury from typing now with low back pain radiating into the legs with associated weakness, numbness and tingling. The lumbar spine and lower extremities exam indicated no deformities, non-tender para-spinal muscles with decreased range (no degree documented), decreased sensation (no specific dermatome noted), and normal gait, motor, and reflexes. The electrodiagnostic impression had normal EMG and NCV studies of the lower extremities without acute or chronic denervation or nerve entrapment. The MRI of the lumbar spine had impression: essentially unremarkable MRI of the lumbar spine; minimal posterior facet degenerative changes at L4-5. The EMG/NCV of the upper extremities on 4/23/13 had normal findings without acute denervation, cervical radiculopathy or peripheral nerve entrapment. The medical report dated 7/26/13 from [REDACTED] noted patient c/o headaches, neck, upper back, low back, bilateral shoulders, bilateral elbows, and bilateral wrists pain radiating to the hands and legs associated with numbness, weakness; anxiety, and sleep interruption. The objective findings list vital signs, previous diagnostics, cervical spine with tenderness, healed scars, and limited range; lumbar spine with tenderness of paralumbar muscles, decreased range and sensation of the lower extremities (no dermatome documented), yet under neurological exam: no motor and sensory deficits with DTRs 2+ bilaterally. The diagnoses include chronic neck pain syndrome 2nd to cervical spinal stenosis s/p interbody fusion on 9/11/12; Disc protrusion C3-4 and C4-5 with mild spinal stenosis; chronic low back pain syndrome with bilate

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV of bilateral lower extremities: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

Decision rationale: The current requested EMG/NCV of bilateral lower extremities was non-certified, but there is a physical medicine and rehabilitation and electrodiagnostic consultative report dated 7/25/13 by [REDACTED] noted history of repetitive injury from typing now with low back pain radiating into the legs with associated weakness, numbness and tingling. The lumbar spine and lower extremities exam indicated no deformities, non-tender para-spinal muscles with decreased range (no degree documented), decreased sensation (no specific dermatome noted), and normal gait, motor, and reflexes. The electrodiagnostic impression had normal EMG and NCV studies of the lower extremities without acute or chronic denervation or nerve entrapment. The MRI of the lumbar spine had impression: essentially unremarkable MRI of the lumbar spine; minimal posterior facet degenerative changes at L4-5. Per MTUS Guidelines, without specific symptoms or neurological compromise consistent with radiculopathy, foraminal or spinal stenosis, medical necessity for EMG and NCS of the Lower extremities have not been established. The EMG/NCV of bilateral lower extremities is not medically necessary and appropriate.

lumbar spine pillow: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Aetna Medical Clinical Policy Bulletin, Online

Decision rationale: Although MTUS, ACOEM, ODG Guidelines do not specifically address or have recommendations for this DME, other guidelines such as [REDACTED] contractual definition of durable medical equipment (DME) in that they are not durable and because they are not primarily medical in nature and not mainly used in the treatment of disease or injury. It further states "Cushions may be covered if it is an integral part of, or a medically necessary accessory to, covered DME. For example, see CPB 271 - Wheelchairs and Power Operated Vehicles (Scooters) (wheelchair seat cushions are covered to prevent or treat severe burns or decubiti). Certain specialized support surfaces may be covered when medically necessary to prevent or treat decubitus ulcers. For medical necessity criteria for specialized cushions to prevent decubiti, see CPB 430 - Pressure Reducing Support Surfaces." These criteria are not met for this May 2010 upper extremity cumulative trauma injury. The lumbar spine pillow is not medically necessary and appropriate.

IF 4 unit for home use: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Section Page(s): 115-118.

Decision rationale: The medical report dated 7/26/13 from [REDACTED] noted patient amongst other complaints with low back pain radiating to legs associated with numbness, weakness. The objective of the lumbar spine with tenderness of paralumbar muscles, decreased range and sensation of the lower extremities (no dermatome documented), yet under neurological exam: No motor and sensory deficits with DTRs 2+ bilaterally. The treatment included chiropractic care and IF-4 Unit for home use. The MTUS guidelines recommend a one-month rental trial of TENS unit to be appropriate to permit the physician and provider licensed to provide physical therapy to study the effects and benefits, and it should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) as to how often the unit was used, as well as outcomes in terms of pain relief and function; however, there are no documented failed trial of TENS unit or functional improvement such as increased ADLs, decreased medication dosage, increased pain relief or improved work status derived from any transcutaneous electrotherapy to warrant a purchase of an interferential unit for home use for this May 2010 cumulative trauma injury. The IF-4 unit for home use is not medically necessary and appropriate.

four (4) chiropractic treatments: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Section Page(s): 58-60.

Decision rationale: The California MTUS Guidelines supports chiropractic manipulation for musculoskeletal injury. The intended goal is the achievement of positive musculoskeletal conditions via positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. From records review, it is unclear how many sessions have been completed. Per medical report dated 7/26/13 from [REDACTED], treatment plan was for 4 sessions of chiropractic sessions. It appears the patient has received extensive previous conservative treatment to include chiropractic care; however, continues with chronic spine and 4 extremity pain without functional improvement, remaining on significant unchanged work restrictions for this May 2010 cumulative trauma injury. There is no report of acute flare-ups or new red-flag findings nor are there any documented functional benefit derived from treatment already rendered. The four (4) chiropractic treatments are not medically necessary and appropriate.

Capsaicin gel 60gm: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Section Page(s): 111-113.

Decision rationale: Per the California MTUS Chronic Pain Guidelines, the efficacy in clinical trials for topical analgesic treatment modality has been inconsistent and most studies are small and of short duration. These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. There is little evidence to utilize topical analgesic Capsaicin gel over oral NSAIDs or other pain relievers for a patient without contraindication in taking oral medications. Submitted reports have not adequately demonstrated the indication or medical need for this topical analgesic. In addition, although guidelines recommend Capsicum Creams for Chronic Low Back Pain or Other Chronic Persistent Pain, it is for short-term treatment of acute exacerbations of chronic LBP with indications for temporary flare ups of chronic LBP or other chronic persistent pain. Duration of use for patients with chronic pain is limited to an acute flare-up period, generally lasting no more than 2 weeks. The patient has chronic persistent pain without report of flare-ups. Capsaicin cream/gel is recommended only as an option in patients who have not responded or are intolerant to other treatments. There have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. Current request only identified 60 gm gel without dosing formulation. The Capsaicin gel 60gm is not medically necessary and appropriate.