

Case Number:	CM13-0021472		
Date Assigned:	02/03/2014	Date of Injury:	11/03/2008
Decision Date:	04/22/2014	UR Denial Date:	08/26/2013
Priority:	Standard	Application Received:	09/09/2013

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, has a subspecialty in Pain Management 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:

This is a patient with a date of injury of 11/3/08. 6/11/13 medical report identifies headaches, low back pain, bilateral shoulder pain, bilateral forearm and right wrist pain, right hip pain, bilateral ankle pain, anxiety, tension, and lots of pressure, sleep interruption, and trouble falling asleep. The patient is known to have arthritis and hypertension. On exam, there is paraspinal tenderness and SLR 60 degrees with pain in the low back and posterior thighs. There is tenderness over the iliac.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI OF THE CERVICAL SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): table 8-7. Decision based on Non-MTUS Citation Special studies and diagnostic and treatment considerations for the low back page 303

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, MRI.

Decision rationale: Regarding the request for MRI OF THE CERVICAL SPINE, California MTUS does not address repeat MRIs. ODG cites that repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation). Within the documentation available for review, there is documentation of some increased symptoms since the patient returned to work, but no symptoms/findings suggestive of radiculopathy or another significant pathology. In light of the above issues, the currently requested MRI OF THE CERVICAL SPINE is not medically necessary.

MRI OF THE LUMBAR SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): table 8-7. Decision based on Non-MTUS Citation Special studies and diagnostic and treatment considerations and chapter 12 Special studies and diagnostic and treatment considerations for the low back page 303.

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, MRI

Decision rationale: Regarding the request for MRI OF THE LUMBAR SPINE, California MTUS does not address repeat MRIs. ODG cites that repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation). Within the documentation available for review, there is documentation of some increased symptoms since the patient returned to work, but no symptoms/findings suggestive of radiculopathy or another significant pathology. In light of the above issues, the currently requested MRI OF THE LUMBAR SPINE is not medically necessary.

EMG/NCV OF THE UPPER EXTREMITIES AND LOWER EXTREMITIES: Upheld

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 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 178, 182,303.

Decision rationale: Regarding the request for EMG/NCV OF THE UPPER EXTREMITIES AND LOWER EXTREMITIES, CA MTUS states that electromyography and nerve conduction velocities including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm/low back symptoms lasting more than three or four weeks. Within the documentation available for review, there are no recent physical examination findings identifying focal neurologic deficits for which the use of electrodiagnostic testing would be indicated. In the absence of such documentation, the currently requested EMG/NCV OF THE UPPER EXTREMITIES AND LOWER EXTREMITIES is not medically necessary.

LABORATORY ARTHRITIS PANEL: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://labtestsonline.org/understanding/conditions/rheumatoid/start/1>.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence

Decision rationale: Regarding the request for LABORATORY ARTHRITIS PANEL, California MTUS does not address the issue. Furthermore, the specific laboratory tests requested are not clearly identified. It is also noted that a consultation with a rheumatologist was authorized, and the need for specific laboratory tests for a systemic arthritic condition will likely depend in part on the findings of that exam. In light of the above issues, the currently requested LABORATORY ARTHRITIS PANEL is not medically necessary.

WELLBUTRIN SR 100MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-16.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 402.

Decision rationale: Regarding the request for WELLBUTRIN SR 100MG, California MTUS cites that brief courses of antidepressants may be helpful to alleviate symptoms of depression. Within the documentation available for review, there is a notation of depression and that the patient is less depressed. However, the requested number of tablets/duration is not documented. In light of the above issues, the currently requested WELLBUTRIN SR 100MG is not medically necessary.

PHYSICAL THERAPY TO THE NECK AND LOWER BACK ONCE A WEEK FOR FOUR WEEKS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation Page(s): 58-60.

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

Decision rationale: Regarding the request for PHYSICAL THERAPY TO THE NECK AND LOWER BACK ONCE A WEEK FOR FOUR WEEKS, California MTUS cites that "patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels." Within the documentation available for review, the patient has a longstanding injury and it appears that the patient has received prior

physical medicine treatment, but there is no documentation of specific objective functional deficits and why they cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. In light of the above issues, the currently requested PHYSICAL THERAPY TO THE NECK AND LOWER BACK ONCE A WEEK FOR FOUR WEEKS is not medically necessary.

CHIROPRACTIC EVALUATION AND TREATMENT TO THE NECK AND LOW BACK ONCE A WEEK FOR FOUR WEEKS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation Page(s): 58-60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-60.

Decision rationale: Regarding the request for CHIROPRACTIC EVALUATION AND TREATMENT TO THE NECK AND LOW BACK ONCE A WEEK FOR FOUR WEEKS, CA MTUS Chronic Pain Medical Treatment Guidelines support the use of chiropractic care for the treatment of chronic pain caused by musculoskeletal conditions. Guidelines go on to recommend a trial of up to 6 visits over 2 weeks for the treatment of low back pain. With evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks may be supported. Within the documentation available for review, the patient has a longstanding injury and it appears that the patient has received chiropractic treatment, but there is no documentation of specific objective functional deficits and why they cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised treatment. In light of the above issues, the currently requested CHIROPRACTIC EVALUATION AND TREATMENT TO THE NECK AND LOW BACK ONCE A WEEK FOR FOUR WEEKS is not medically necessary.