

Case Number:	CM13-0024149		
Date Assigned:	03/26/2014	Date of Injury:	07/01/2012
Decision Date:	04/25/2014	UR Denial Date:	08/12/2013
Priority:	Standard	Application Received:	09/13/2013

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 Interventional Spine 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 patient is a 53-year-old male with date of injury 07/01/2012. Per treating physician report 07/22/2013, listed diagnoses are cervical spine discopathy, right shoulder impingement syndrome, right shoulder calcific tendinitis, lumbar spine discopathy, right upper extremity radiculopathy, right/left CTS, status post posterior cervical instrumental fusion, lower extremity radiculitis. Recommendation for GI consultation with a specialist for ongoing GI symptomatology, sleep studies, physical therapy for cervical and lumbar spine 2 times a week for 6 weeks, CT scan of the C-spine, as well as MRI scan of the lumbar spine. Another report by treating physician from 06/27/2013 states that the patient has an industrial injury to the neck, bilateral wrists, hands, low back, bilateral lower extremities, GI (Gastro Intestinal) system, sleep disorder, and a continued trauma basis. When the patient initially presented with problems, apparently there was an MRI scan that showed pinged spinal cord, and surgery was recommended. Surgery was performed on 08/12/2012 for fusion and instrumentation, but the patient was provided with little physical therapy with no benefit, and surgery was not successful, with pain persistent at 8/10. Toward the end of 2012 due to continued low back pain, an MRI scan was obtained and was recommended for surgery. On 01/12/2013, lumbar surgery was performed to remove disk, at [REDACTED] Postoperatively treated with back brace, little physical therapy, and medications, but patient presented with worst pain with radiation down in both lower extremities at 7/10 to 8/10. Recommendation was for MRI of the lumbar spine, CT scan of C-spine (cervical), EMG/NCV (Electromyogram/ Nerve conduction velocity) studies to both upper and lower extremities, as well as other requests.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI OF THE LUMBAR SPINE: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), (http://www.odg-twc.com/odgtwc/low_back.htm#Protocols)

Decision rationale: This patient presents with persistent low back pain despite having had lumbar surgery for discectomy at [REDACTED] ACOEM Guidelines address a special diagnostic, but this refers to acute and subacute phase. ODG Guidelines do support MRI scans particularly for postoperative evaluation. This patient has had lumbar surgery without much benefit. The patient has persistent pain down both lower extremities, and an updated MRI of the lumbar spine with contrast would be reasonable and consistent with ODG Guidelines. Recommendation is for authorization.

CT SCAN OF THE CERVICAL SPINE: Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG)

Decision rationale: The patient apparently presented with neck injury, an MRI showing a spinal cord impingement, and cervical spine discectomy and instrumented fusion was performed at [REDACTED] The patient apparently received very little therapy following the procedure. Unfortunately, the patient has persistent pain in the neck at an intensity of 8/10. The treating physician has requested CT scan of the cervical spine. Although MRI scans were superior, CT scans are recommended following fusion surgeries and instrumentation. ODG Guidelines support CT scan for C-spine (Cervical) following surgery for assessment of fusion and also instrumentation. Recommendation is for authorization.

EMG (ELECTROMYOGRAM) OF THE UPPER EXTREMITIES: Overturned

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): 303.

Decision rationale: This patient presents with persistent neck pain and upper extremities symptoms. Review of the reports does not show that this patient has had electrodiagnostic

studies prior to this request. Electrodiagnostic studies were provided from 08/01/2013, but this was obtained without authorization after the request was made. ACOEM Guidelines do support electrodiagnostic studies to evaluate radicular symptoms to differentiate radiculopathy versus carpal tunnel syndrome as well as peripheral neuropathy. In this patient, given that the patient has not had electrodiagnostic studies prior to the treater's request and given the patient's persistent symptoms in the upper extremities and the fact that the patient has had prior cervical spine surgery with instrumentation/fusion, electrodiagnostic studies of the upper extremities are medically indicated. Recommendation is for authorization.

EMG OF THE LOWER EXTREMITIES: Overturned

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): 303.

Decision rationale: This patient presents with persistent pain in the low back with radiation down to both lower extremities. The patient has had lumbar surgery for disectomy at [REDACTED], but continues to experience persistent pain. Review of the reports shows that this patient has not had EMG studies of the lower extremities. ACOEM Guidelines page 303 support EMG studies along with H-reflex studies for evaluation of low back pain to determine focal neurologic deficits. Recommendation is for authorization.

NCV (NERVE CONDUCTION VELOCITY) OF THE UPPER EXTREMITIES:
Overturned

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): 303.

Decision rationale: This patient presents with persistent neck pain and upper extremities symptoms. Review of the reports does not show that this patient has had electrodiagnostic studies prior to this request. Electrodiagnostic studies were provided from 08/01/2013, but this was obtained without authorization after the request was made. ACOEM Guidelines do support electrodiagnostic studies to evaluate radicular symptoms to differentiate radiculopathy versus carpal tunnel syndrome as well as peripheral neuropathy. In this patient, given that the patient has not had electrodiagnostic studies prior to the treater's request and given the patient's persistent symptoms in the upper extremities and the fact that the patient has had prior cervical spine surgery with instrumentation/fusion, electrodiagnostic studies of the upper extremities are medically indicated. Recommendation is for authorization.

NCV (NERVE CONDUCTION VELOCITY) OF THE LOWER EXTREMITIES:
Overturned

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): 303.

Decision rationale: This patient presents with low back pain, radiating symptoms to lower extremities. The request is for NCV studies. ACOEM Guidelines support EMG studies along with H-reflex for evaluation of lumbar spine. However, ODG Guidelines do not support routine use of nerve conduction studies when radiating symptoms of the leg are presumed to be coming from the lumbar spine. In this patient, the patient's leg symptoms are radiating from the lumbar spine. There is no need for routine use of nerve conduction studies per ODG Guidelines. Recommendation is for denial.

GI CONSULT: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Page(s): 127.

Decision rationale: This patient presents with industrial injury involving neck and low back. The patient has been complaining of GI irritation and problems. The treater has asked for GI specialist consult. ACOEM Guidelines page 127 allows for specialty referrals for complex cases. In this patient, given the complexity of the patient's chronic pain, multiple bodies involved, and persistent GI complaints, GI specialist consultation is medically reasonable and supported by the Guidelines. Recommendation is for authorization.

SLEEP STUDY CONSULT: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Treatment Guidelines Pain Chapter, Polysomnography and AMA guides (5th ed.), pages 3-17

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), POLYSOMNOGRAPHY. AND AMA GUIDES (5TH ED.), PAGES 3-17

Decision rationale: This patient presents with chronic neck and low back pain with recent surgery in the cervical and lumbar spine. Patient has had difficulty sleeping due to chronic pain condition. The treating physician has asked for sleep studies consult. ACOEM and MTUS Guidelines do not discuss polysomnography. However, ODG Guidelines state that sleep studies are recommended for combination of indications including excessive daytime somnolence, cataplexy, morning headaches, intellectual deterioration, personality change, insomnia complaints for at least 6 months, unresponsive to behavior interventions, sedative sleep

promoting medications and psychiatric etiology has been excluded. In this patient, none of these criteria have been met. There is no documentation of daytime somnolence, cataplexy, morning headaches, intellectual deterioration, personality changes, etc. A routine sleep studies for insomnia without these evaluations and documentations are not recommended. Therefore the request of sleep study consult is not medically necessary and appropriate.

PHYSICAL THERAPY 2 TIMES A WEEK FOR 4 WEEKS FOR THE CERVICAL AND LUMBAR SPINE: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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

Decision rationale: This patient presents with persistent neck and low back symptoms, status post surgeries to both areas. The treating physician indicates that the patient has surgery at [REDACTED] for instrumented fusion of the C-spine, and discectomy, laminectomy of the lumbar spine. He states that a very little physical therapy was provided following these surgeries. The patient continues to have severe pain in both the neck and low back at an intensity of 8/10, in fact, increased pain in this areas following surgery. Review of the reports does not include physical therapy notes to determine exactly how many sessions were provided in the past. MTUS Guidelines allow up to 9 to 10 therapy sessions for myalgia/myositis, neuritis/radiculitis/neuralgia type of condition.

A PRIME DUAL MUSCLE STIMULATOR: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 121.

Decision rationale: This patient presents with chronic, persistent neck and low back pain having had surgery in both areas. The treating physician has asked for Prime Dual muscle stimulator to help manage this patient's chronic and persistent pain. MTUS Guidelines states on page 121 that neuromuscular electrical stimulation is not recommended and that this is primarily used as part of the rehabilitation program following stroke. It further states, "There is no evidence to support its use in chronic pain." Given the request for muscle stimulator to be used for this patient's chronic pain and not for a stroke condition, as such the request for a PRIME dual muscle stimulator is not medically necessary and appropriate.