

Case Number:	CM13-0037363		
Date Assigned:	05/21/2014	Date of Injury:	05/15/2012
Decision Date:	08/05/2014	UR Denial Date:	10/03/2013
Priority:	Standard	Application Received:	10/23/2013

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 Occupational Medicine 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:

Patient is a 42-year-old female who has submitted a claim for lumbar sprain, lumbar radiculopathy versus neuropathy, and displacement of cervical intervertebral disks without myelopathy associated with an industrial injury date of 05/15/2012. Medical records from 2013 were reviewed. Patient complained of low back pain described as constant, moderate, dull, sharp and cramping. Patient denied radiating pain. There was no numbness, tingling, or burning sensation in the lower extremities. On physical examination, gait was antalgic. No atrophy was noted. Muscle spasm and decreased range of motion of the lumbar spine on all planes were observed. Motor, reflexes and sensory exam were unremarkable. Straight leg raise test was negative bilaterally. EMG/NCV of the bilateral lower extremities, dated February 22, 2014, revealed right L5 radiculopathy. MRI of the lumbar spine, dated 11/12/2007, demonstrated L5 to S1 disc space significant for a 1 cm large extrusion compressing the thecal sac and left S1 nerve root. MRI of the lumbar spine, dated July 31, 2012, showed degenerative disks changes, multilevel disc protrusion, and moderate bilateral proximal foramina stenosis at L5 to S1 level. X-ray of the lumbar spine was unremarkable. Treatment to date has included lumbar surgery, L5 to S1 microdiscectomy, activity restrictions, physical therapy, chiropractic care, aquatic therapy, use of hot/cold modalities, and medications such as Tylenol, Gabapentin, topical capsaicin, and ibuprofen. Utilization review from October 3, 2013 denied the request for MRI of the lumbar spine because patient already had a previous MRI and there were no new complaints of trauma, or physical findings that warranted repeat testing; denied EMG/NCV of bilateral lower extremities because there was no evidence of radiculopathy; denied aquatic therapy because patient was expected to be in a self-directed home exercise program; denied interferential unit because there was no documentation that pain was ineffectively controlled by medications; and modified the request for acupuncture to 4 sessions as trial.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI LUMBAR: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Section, MRI.

Decision rationale: As stated on pages 303-304 of the ACOEM Practice Guidelines referenced by CA MTUS, imaging of the lumbar spine is recommended in patients with red flag diagnoses where plain film radiographs are negative; unequivocal objective findings that identify specific nerve compromise, failure to respond to treatment, and consideration for surgery. In addition, Official Disability Guidelines recommends MRI for the lumbar spine for uncomplicated low back pain, with radiculopathy, after at least 1 month of conservative therapy, sooner if severe, or progressive neurologic deficit. In this case, patient complained of low back pain described as constant, moderate, dull, sharp and cramping. Patient denied radiating pain, numbness, tingling, or burning sensation at the lower extremities. Physical examination showed muscle spasm and decreased range of motion of the lumbar spine on all planes. Motor, reflexes and sensory exam were unremarkable. Straight leg raise test was negative bilaterally. There was no documented rationale for this request. Moreover, MRI of the lumbar spine was already accomplished on July 31, 2012, showing degenerative disks changes, multilevel disc protrusion, and moderate bilateral proximal foramina stenosis at L5 to S1 level. There was no worsening of subjective complaints and objective findings that may warrant repeat MRI. Therefore, the request for MRI of the lumbar spine is not medically necessary.

NERVE CONDUCTION VELOCITY (NCV) TO THE BILATERAL LOWER EXTREMITIES: 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 Official Disability Guidelines, (ODG), Low Back chapter, Nerve conduction studies (NCS).

Decision rationale: The CA MTUS does not address NCS specifically. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines, (ODG), Low Back Chapter, Nerve Conduction Studies (NCS) was used instead. The Official Disability Guidelines state that the conduction studies are not recommended. There is minimal justification for performing nerve conduction studies when the patient is presumed to have symptoms on the basis of radiculopathy.

In this case, patient complained of low back pain described as constant, moderate, dull, sharp and cramping. Patient denied radiating pain, numbness, tingling, or burning sensation at the lower extremities. Relevant objective findings were muscle spasm and decreased range of motion of the lumbar spine on all planes. Clinical manifestations were not consistent with neuropathy. There was no documented rationale for this request. Therefore, the request for nerve conduction velocity (NCV) study of bilateral lower extremities is not medically necessary.

ELECTROMYOGRAPHY (EMG) TO THE 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): 303.

Decision rationale: According to page 303 of CA MTUS ACOEM Low Back Chapter, the guidelines support the use of electromyography (EMG) to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three to four weeks. In this case, patient complained of low back pain described as constant, moderate, dull, sharp and cramping. Patient denied radiating pain, numbness, tingling, or burning sensation at the lower extremities. Relevant objective findings were muscle spasm and decreased range of motion of the lumbar spine on all planes. No atrophy was noted. Motor, reflexes and sensory exam were unremarkable. Clinical manifestations were not consistent with radiculopathy. There was no documented rationale for this request. Therefore, the request for electromyography (EMG) of the bilateral lower extremities is not medically necessary.

AQUATIC THERAPY: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy Page(s): 22-23.

Decision rationale: As stated on pages 22-23 of the California MTUS Chronic Pain Medical Treatment Guidelines, aquatic therapy is recommended as an alternative to land-based physical therapy where reduced weight bearing is desirable such as extreme obesity or fractures of the lower extremity. In this case, patient underwent physical therapy and aquatic therapy sessions in the past. However, total number of sessions and functional outcomes were not documented. Moreover, the request failed to specify body part to be treated and quantity of sessions. There is no compelling rationale for water-based therapy. Therefore, the request for aquatic therapy is not medically necessary.

URINE TOXICOLOGY SCREEN: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-going Management Page(s): 78.

Decision rationale: Page 78 of the CA MTUS Chronic Pain Medical Treatment Guidelines state that urine drug screens are recommended as an option to assess order use or presence of illegal drugs and as ongoing management for continued opioid use. It is likewise recommended upon initiation of opioid. Screening is recommended randomly at least twice and up to 4 times a year. In this case, current treatment regimen does not include opioid. There is likewise no plan to initiate its use. There is no documented rationale for drug screen. Therefore, the request for urine drug screen is not medically necessary.

INTERFERENTIAL STIMULATION (IF) UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-120.

Decision rationale: As stated on pages 118-120 of the California MTUS Chronic Pain Medical Treatment Guidelines, interferential current stimulation is not recommended as an isolated intervention but is an adjunct for recommended treatments including return to work, exercise, and medications. A one-month trial should be done given that the patient's pain is ineffectively controlled by medications, or unresponsive to conservative measures. In this case, patient complained of persistent low back pain despite physical therapy, aquatic therapy, hot/cold modalities, chiropractic care, and intake of medications. Use of interferential current stimulation is a reasonable option at this time. However, there was no documentation that patient is currently participating in a home exercise program, which is a necessary adjunct for IF use. Guideline criteria were not met. Moreover, the request failed to specify if the device is for rental or purchase. Body part to be treated and duration of use are likewise not stated. Therefore, the request for interferential stimulation unit is not medically necessary.

ACUPUNCTURE 1X6 TO LUMBAR: Overturned

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: CA MTUS Acupuncture Medical Treatment Guidelines state that acupuncture is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Acupuncture treatments may be extended if functional improvement is documented.

The frequency and duration to produce functional improvement is 3 - 6 treatments, frequency of 1 - 3 times per week, and duration of 1 - 2 months. It may be extended if functional improvement is documented. In this case, patient complained of persistent low back pain despite physical therapy, aquatic therapy, hot/cold modalities, chiropractic care, and intake of medications. Acupuncture is a reasonable option at this time. Therefore, the request for Acupuncture 1 x 6 to lumbar is medically necessary.