

Case Number:	CM13-0054892		
Date Assigned:	12/30/2013	Date of Injury:	06/14/2013
Decision Date:	03/17/2014	UR Denial Date:	10/23/2013
Priority:	Standard	Application Received:	11/15/2013

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 Family Practice, and is licensed to practice in Texas. 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:

The patient is a 29-year-old male who reported an injury on 06/14/2013. The mechanism of injury was not provided for review. The patient's most recent clinical examination findings included complaints of cervical spine pain rated at a 5/10 and complaints of lumbosacral pain rated at an 8/10. Physical findings included tenderness to palpation of the bilateral arms with pain radiating from the cervical spine. It is noted that the patient has previously participated in physical therapy for this injury. The patient's diagnoses included degenerative disc disease of the cervical spine with radiculopathy and degenerative disc disease of the lumbar spine with radiculopathy. Patient's treatment plan included an MRI of the cervical and lumbar spine, an EMG/NCV of the upper and lower extremities, medications, and an interferential unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 2 x 4: Upheld

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

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

Decision rationale: The requested physical therapy 2x4 is not medically necessary or appropriate. The MTUS Guidelines recommend up to 10 visits of physical therapy for radicular pain. The clinical documentation does indicate that the employee has previously participated in physical therapy for this injury. It is noted that the employee received "good" results. However, the duration and frequency of the previously physical therapy was not addressed. Additionally, there were very limited examination findings to support functional benefit as a result of the prior therapy. Therefore, additional therapy would not be supported. As such, the requested PTx4 is not medically necessary or appropriate.

Topical Cream: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47.

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

Decision rationale: Requested topical cream is not medically necessary or appropriate. The MTUS Guidelines do not recommend the use of topical agents as they are largely experimental and there is little scientific evidence to support the efficacy and safety of these formulations. Additionally, the clinical documentation does not clearly identify the components of the requested topical cream. Therefore, the appropriateness of this medication cannot be determined. As such, the requested topical cream is not medically necessary or appropriate.

MRI lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304 and Table 12-8.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The ACOEM Guidelines recommend imaging studies for the lumbar spine when there is documentation of neurological deficit. The clinical documentation submitted for review does not provide any evidence of neurological deficit that would require clarification from an imaging study. Therefore, the requested MRI of the lumbar spine is not medically necessary or appropriate.

EMG/NCS bilateral upper and lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 238.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The requested EMG/NCS of the bilateral upper and lower extremities is not medically necessary or appropriate. The ACOEM Guidelines recommend electrodiagnostic studies if there is a suggestion of radicular findings during the examination that would benefit from further clarification. The clinical documentation submitted for review did not provide any evidence of radicular symptoms that would benefit from further clarification. Therefore, the need for an electromyography/nerve conduction study of the bilateral upper and lower extremities is not medically necessary or appropriate.

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.

Decision rationale: The requested interferential unit is not medically necessary or appropriate. The MTUS Guidelines recommend an interferential unit when the patient has exhausted all other types of conservative treatments to include physical therapy and a TENS unit. The clinical documentation submitted for review does not provide any evidence that the employee has had pain that has failed to respond to a TENS unit. Additionally, the MTUS Guidelines do not recommend the use of an interferential unit as a stand alone treatment. The clinical documentation submitted for review does not provide any evidence that the employee is participating in a home exercise program that would benefit from an adjunct therapy such as an interferential unit. As such, the requested interferential unit is not medically necessary or appropriate.