MAXIMUS Federal Services

Case Number:	CM13-0069910		
Date Assigned:	01/03/2014	Date of Injury:	09/25/2013
Decision Date:	06/19/2014	UR Denial Date:	12/16/2013
Priority:	Standard	Application Received:	12/23/2013

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 Anesthesiology, 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:

The patient has submitted a claim for cervical/lumbosacral radiculopathy; left knee sprain/strain; and right knee meniscus tear associated with an industrial injury date of September 25, 2013. Treatment to date has included; physical therapy, home exercise program, use of a knee brace, and medications such as Vicodin, Flexeril, omeprazole, ibuprofen, and topical medications. The medical records from 2013 were reviewed, showing that patient complained of pain at the cervical spine and lumbar spine described as constant, moderate, dull, achy, sharp with associated stiffness. It radiated to bilateral upper extremities and left lower extremity described as throbbing, shooting, with tingling sensation. The pain was aggravated by looking up, looking down, turning, sitting, standing, bending, and squatting. The patient likewise complained of left knee pain and weakness. This resulted to difficulty doing household chores, climbing stairs, carrying kids, and traveling. The physical examination revealed tenderness and muscle spasm of the cervical and lumbar paravertebral muscles and suboccipitals. The range of motion one of both the cervical and lumbar spine was restricted and painful. Shoulder depression was positive bilaterally. The cervical compression was positive. Trigger points were present at the paralumbar spine. The Kemp's test and McMurray's test were positive. There were motor deficits of the deltoid, biceps, wrist flexors, triceps, finger extensors, hip flexors, hip adductors, quadriceps, ankle plantarflexors and extensor hallucis longus on the left. The biceps and triceps reflexes were diminished on the right, and absent on the left. Sensation was diminished at C7, C8, L1 to L3 dermatomes, left. The utilization review from December 16, 2013, denied the requests for Electromyography/ Nerve Conduction Velocity study (EMG/NCV) for the bilateral upper and lower extremities due to lack of evidence of neurologic deficits; home transcutaneous nerve stimulation (TENS) unit, due to incomplete review of the past history; and Neurostimulation therapy for six (6) sessions at the lumbar spine, because it is not recommended.

The reasons for the denial of initial physical therapy twice (2) per week for four (4) weeks toward the lumbar spine and cervical spine; and MRI of the cervical spine were not made available.

IMR ISSUES, DECISIONS AND RATIONALES

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

NERVE CONDUCTION VELOCITY (NCV) TESTING FOR THE BILATERAL UPPER AND LOWER EXTREMITIES: Overturned

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 11 Forearm, Wrist, and Hand Complaints Page(s): 253-285. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Nerve Conduction Studies (NCS).

Decision rationale: The MTUS/ACOEM guidelines state that appropriate electrodiagnostic studies may help differentiate between carpal tunnel syndrome and other conditions, such as cervical radiculopathy. On the other hand, the Official Disability Guidelines state that electrodiagnostic testing should be medically indicated (i.e., to rule out radiculopathy, lumbar plexopathy, and peripheral neuropathy). In this case, patient has been complaining of persistent neck pain radiating to bilateral upper extremities; and back pain radiating to left lower extremity. It was described as throbbing, shooting, with tingling sensation. This is corroborated by physical examination findings of weakness, hyporeflexia, positive provocative tests, and diminished sensation. The guideline criteria have been met. Therefore, the request for Nerve Conduction Velocity (NCV) testing for the bilateral upper and lower extremities is medically necessary.

ELECTROMYOGRAPHY (EMG) FOR THE BILATERAL UPPER AND LOWER EXTREMETIES: Overturned

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 Page(s): 177-178. Decision based on Non-MTUS Citation Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12), Page 303

Decision rationale: The MTUS/ACOEM guidelines state that electromyography (EMG) studies may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, and low back symptoms lasting more than three (3) or four (4) weeks. In this case, the patient has been complaining of persistent neck pain radiating to bilateral upper extremities; and back pain radiating to left lower extremity. It was described as throbbing, shooting, with tingling sensation. This is corroborated by physical examination findings of weakness, hyporeflexia, positive provocative tests, and diminished sensation. The guideline criteria have been met.

Therefore, the request for electromyography (EMG) testing for the bilateral upper and lower extremities is medically necessary.

HOME TENS (TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION) UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tens Page(s): 114 and 116.

Decision rationale: According to the Chronic Pain Guidelines, Transcutaneous Electrical Nerve Stimulator (TENS) units are not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. The guidelines state that a treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted. In this case, the patient already underwent physical therapy; however, no functional improvement was noted. The stated goals for initiating TENS unit include: to decrease pain and to help increase her range of motion. However, the present request failed to specify if the device is for rental or purchase purposes. The guidelines recommend an initial trial of one (1) month; thus, a rental unit can suffice. In addition, the request did not specify the duration of time for use. Therefore, the request for a Home Transcutaneous Electrical Nerve Stimulator (TENS) unit is not medically necessary.

LOCALIZED INTENSE NEUROSTIMULATION THERAPY (LINT) FOR THE LUMBAR SPINE, SIX SESSIONS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM Guidelines, Electrical Therapy

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, LINT, and A Novel Image-Guided, Automatic High-Intensity Neurostimulation Device for the Treatment of Nonspecific Low Back Pain, Pain Research and Treatment, 2011, 152307 (http://www.ncbi.nlm.nih.gov/pmc/articles/pms195366/)

Decision rationale: The article entitled, "A Novel Image-Guided, Automatic, High-Intensity Neurostimulation Device for the Treatment of Nonspecific Low Back Pain"stated that the pilot study investigated the effectiveness of a novel device in the management of chronic low back pain. The conclusion cited that further investigation of the use of Localized Intense Neurostimulation Therapy (LINT) in the treatment of lower back pain (LBP) is required. In this case, the goals for Localized Intense Neurostimulation Therapy (LINT) include: to increase range of motion, to improve activities of daily living, and to decrease pain. The Official Disablity Guidelines states that the LINT is not recommended until there are higher quality

studies. Initial results are promising, but only from two (2) low quality studies sponsored by the manufacturer. However, the proposed treatment modality is not consistently or overwhelmingly supported by applicable guidelines. It is still on its experimental stage, thus, and is not recommended. The requesting provider does not establish circumstances that would warrant LINT therapy despite lack of positive evidence. Therefore, the request for Localized Intense Neurostimulation Therapy (LINT) for the lumbar spine, six (6) sessions is not medically necessary.

INITIAL PHYSICAL THERAPY OF THE LUMBAR AND CERVICAL SPINE, TWICE PER WEEK FOR FOUR WEEKS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation,Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

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

Decision rationale: According to the Chronic Pain Guidelines, physical medicine is recommended and that a given frequency should be tapered and transitioned into a self-directed home program. In this case, the present request is for an initial physical therapy program. However, a progress report dated 12/06/2013 specifically stated that the patient had failed conservative treatment, including physical therapy. The medical records submitted and reviewed do not indicate the number of sessions completed and the functional outcomes derived from it. The medical necessity has not been established due to conflicting information in the records. Therefore, the request for initial physical therapy of the lumbar and cervical spine, twice (2) per week for four (4) weeks is not medically necessary.

MRI OF THE CERVICAL SPINE: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-180.

Decision rationale: The MTUS/ACOEM Guidelines support imaging studies with red flag conditions; physiologic evidence of tissue insult or neurologic dysfunction; failure to progress in a strengthening program intended to avoid surgery; clarification of the anatomy prior to an invasive procedure and definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. The rationale given in this case is to rule out internal derangement of the cervical area. The patient has been complaining of persistent neck pain radiating to bilateral upper extremities despite physical therapy. It was described as throbbing, shooting, with tingling sensation. This is corroborated by physical examination findings of weakness, hyporeflexia, positive provocative tests, and diminished sensation. The guideline

criteria have been met. Therefore, the request for MRI of the cervical spine is medically necessary.