

Case Number:	CM14-0010462		
Date Assigned:	02/21/2014	Date of Injury:	08/15/2012
Decision Date:	08/06/2014	UR Denial Date:	12/30/2013
Priority:	Standard	Application Received:	01/24/2014

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:

The patient is a 60-year-old female who has filed a claim for neck sprain associated with an industrial injury date of August 15, 2012. Review of progress notes indicates upper back pain with numbness and tingling radiating to the shoulders and down the spine; pain in the back of the head; low back pain with numbness and tingling radiating to the feet; and radiation of pain to the abdomen. Patient also complains of stress, anxiety, and insomnia. Findings include tenderness over the epigastrium, cervical and thoracolumbar regions, and sacroiliacs; limited range of motion of the cervical and thoracolumbar spines; spasms at the cervical and thoracolumbar regions; and positive sitting nerve root test. X-rays of the cervical spine dated November 01, 2013 showed mild hypertrophic changes with slight decrease in the C5-6 disc level. X-rays of the lumbar spine showed mild hypertrophic changes with dextroscoliosis, and decrease in the L2-3 and L3-4 disc levels. Treatment to date has included physical therapy, acupuncture, chiropractic therapy, sedatives, cold packs, opioids, NSAIDs, and functional restoration. Utilization review from December 30, 2013 denied the requests for outpatient acupuncture and chiropractic treatment 12 sessions as there was no rationale provided for the concurrent application of these modalities; purchase of TENS unit as there were no neurological findings, or of a 30-day trial; and cold therapy unit as there is no indication of where this is to be used. Reasons for denial of EMG/NCV of the lower extremities were not indicated.

IMR ISSUES, DECISIONS AND RATIONALES

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

OUTPATIENT ACUPUNCTURE TREATMENT TWELVE SESSIONS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines, Chronic Pain Treatment Guidelines Pain, Suffering, and the Restoration of Function Page(s): 114.

Decision rationale: As noted on page 114 of the CA MTUS ACOEM Guidelines, they stress the importance of a time-limited treatment plan with clearly defined functional goals, with frequent assessment and modification of the treatment plan based upon the patient's progress in meeting those goals, and monitoring from the treating physician is paramount. In addition, Acupuncture Medical Treatment Guidelines state that acupuncture may be 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. Functional improvement should be observed within 3-6 treatments, with treatments rendered 1 to 3 times per week and an optimum duration of 1 to 2 months. Acupuncture treatments may be extended if functional improvement is documented. In this case, there is mention of previous acupuncture sessions. However, there is no documentation regarding the number of sessions completed, or of the objective functional improvement. In addition, there is no documentation regarding the functional goals of additional acupuncture sessions, or the body part to which these are directed. Additional information is necessary to support this request. Therefore, the request for outpatient acupuncture treatment 12 sessions was not medically necessary.

OUTPATIENT ELECTROMYOGRAPHY (EMG) BILATERAL LOWER EXTREMITY (LE): Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation p. 116, 2010 Revision, Web Edition American College of Occupational and Environmental Medicine (ACOEM) Guidelines: Second Edition, Chapter 12, Low Back, Web Edition.

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

Decision rationale: As stated on page 303 of the ACOEM Low Back Guidelines referenced by CA MTUS, EMGs are indicated to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three to four weeks. In addition, ODG states that EMGs may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious. In this case, the patient presents with persistent symptoms suggestive of lumbar radiculopathy with findings suggestive of nerve root irritation. There is no documentation regarding the specific distribution of the radiating low back pain. An EMG of the lower extremities is a reasonable option to diagnose the presence and level of radiculopathy. Therefore, the request for outpatient electromyography (EMG) bilateral lower extremities (LE) was medically necessary.

OUTPATIENT NERVE CONDUCTION VELOCITY (NCV) BILATERAL LOWER EXTREMITY (LE): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation p. 116, 2010 Revision, Web Edition American College of Occupational and Environmental Medicine (ACOEM) Guidelines: Second Edition, Chapter 12, Low Back, Web Edition.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation X Official Disability Guidelines (ODG) Low Back chapter, Nerve conduction studies (NCS).

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, and ODG was used instead. According to ODG, nerve conduction studies are not recommended when a patient is presumed to have symptoms on the basis of radiculopathy. In this case, the patient presents with persistent symptoms suggestive of lumbar radiculopathy with findings suggestive of nerve root irritation. A nerve conduction velocity is not necessary to diagnose radiculopathy. Therefore, the request for outpatient nerve conduction velocity (NCV) bilateral lower extremities (LE) was not medically necessary.

PURCHASE OF TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR (TENS) UNIT: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, SECOND EDITION, CHAPTER 12, LOW BACK, WEB EDITION.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, TENS (transcutaneous electrical nerve stimulation) Page(s): 114-116.

Decision rationale: As stated on pages 114-116 in the California MTUS Chronic Pain Medical Treatment Guidelines, a one-month home-based TENS trial may be considered as a noninvasive conservative option for neuropathic pain and CRPS, with a rental being preferred over a purchase during this trial. Criteria includes chronic intractable pain (at least 3 months duration), evidence of failure of other appropriate pain modalities, and presence of a treatment plan including specific short- and long-term goals of treatment. In this case, there is no documentation regarding failure of other conservative management strategies, or of a trial of TENS, to support the purchase of a TENS unit. Therefore, the request for purchase of TENS unit was not medically necessary.

PURCHASE OF COLD THERAPY UNIT (CTU): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM SECOND EDITION, CHAPTER 12, LOW BACK, WEB EDITION.

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, Cold/heat packsX Other Medical Treatment Guideline or Medical Evidence: Aetna Clinical Policy Bulletin: Cryoanalgesia and Therapeutic Cold.

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, ODG and Aetna were used instead. ODG low back chapter states that cold/hot packs are recommended as an option for acute pain. Aetna considers the use of the Hot/Ice Machine and similar devices (e.g., the Hot/Ice Thermal Blanket, the TEC Thermoelectric Cooling System (an iceless cold compression device), the Vital Wear Cold/Hot Wrap, and the Vital Wrap) experimental and investigational for reducing pain and swelling after surgery or injury. Studies in the published literature have been poorly designed and have failed to show that the Hot/Ice Machine offers any benefit over standard cryotherapy with ice bags/packs; and there are no studies evaluating its use as a heat source. There is no indication regarding the necessity of a cold therapy unit over cold packs in this patient. Therefore, the request for purchase of cold therapy unit was not medically necessary.

OUTPATIENT CHIROPRACTIC TREATMENTS TWELVE SESSIONS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines state that the goal of manual therapy is to achieve positive symptomatic or objective measurable functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. For the low back, trial of 6 visits is recommended, and with evidence of objective functional improvement, a total of up to 18 visits are supported. In addition, elective/maintenance care is not medically necessary. This patient has had previous chiropractic therapy, but there is no documentation regarding the number of sessions or objective functional benefits derived. Also, the body part to which these sessions are directed to is not indicated. Therefore, the request for outpatient chiropractic treatments 12 sessions was not medically necessary.