

Case Number:	CM14-0015255		
Date Assigned:	02/28/2014	Date of Injury:	05/10/2009
Decision Date:	07/10/2014	UR Denial Date:	01/07/2014
Priority:	Standard	Application Received:	02/06/2014

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 Physical Medicine and Rehabilitation 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 injured worker is a 50-year-old female who reported an injury on 05/10/2009; the mechanism of injury was not cited within the documentation provided. Within the clinical note dated 11/07/2013, the claimant was noted to be symptomatic with some improvement and reports of decreased pain and more movement since the last re-evaluation performed on 10/09/2013. It was noted that the claimant continued to complain of chronic stomach/GI pain, sleeping difficulties and depression. The claimant stated that pain and anti-inflammatory medication only helped relieve the injury symptoms temporarily and sitting for prolonged periods of time increased her back pain and caused radiating pain into her lower extremity. The claimant continued to be unable to stand, sit, bend, stoop, lift, carry, push, pull, or perform household duties or activities of daily living for prolonged periods of time without constant moderate to occasional severe back, bilateral knee with the left knee greater than right and lower extremity pain. The provider indicated the claimant continued to show objective signs of improvement with the treatment administered. Physical examination revealed decreased dorsolumbar active range of motion with flexion to 34/60, extension to 14/25, right rotation to 14/30, left rotation to 14/30, right lateral bending to 16/25, and left lateral bending to 16/25 with frequent moderate pain and point tenderness. There were fibrous adhesions and paraspinal myospasms with the left being greater than the right and paresthesias ran distally into the left lower extremity into the left foot. Right knee active range of motion remained full with frequent moderate pain and crepitus. Left knee active range of motion was decreased with 122/135 degrees of flexion, and 172/180 degrees of extension with frequent moderate pain and crepitus. Apley's and McMurray's test to the left knee produced pain and instability and there was slight swelling to the left knee. Deep tendon reflex to S1 on the left was decreased at 1+ as compared to the right, which was 2+. Resisted muscle testing to the S1 on the left was +4 and remained weak as compared to +5 on the

right. There was a sensory deficit to light touch at L5-S1 on the left side. An EMG/NCV was performed on 11/29/2012 which revealed abnormal results of the lower extremities. The diagnoses included status post left knee arthroscopy, lumbosacral IVD displacement without myelopathy, lumbosacral radiculitis/neuritis, right knee patellar tendinitis and bilateral knee internal derangement. The treatment plan included a request to continue treatment with office visits once per week for the following 4 weeks due to the flare-up of the claimant's injuries and for functional restoration and relief of the claimant's pain, a request for a referral to pain management specialist for lumbar spine epidural injection due to flare-up, a request for a dermatologist for skin irritation on the claimant's hands as it related to the injury, a request for an updated EMG/NCV testing of the lower extremities to objectively monitor the claimant's progress. The requesting physician recommended continuing medical referrals for multidisciplinary care as medically necessary only. No prior treatments were annotated within the clinical note. The Request for Authorization for pain management for lumbar spine epidural injections, physical therapy, dermatology referral and updated EMG/NCV of the lower extremities for the diagnoses of chronic lumbar spine IVD displacement with radiculitis, status post left knee arthroscopy and right knee patellar tendinitis was submitted on 11/07/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE REQUEST FOR CHIROPRACTIC TREATMENT ONE TIME A WEEK FOR FOUR WEEKS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 49.

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

Decision rationale: The California MTUS Guidelines state that chiropractic therapy is recommended for chronic pain if caused by musculoskeletal conditions. Chiropractic therapy is widely used in the treatment of musculoskeletal pain. The intended goal of effect of chiropractic therapy is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the injured worker's therapeutic exercise program and return to productive activities. Chiropractic care is recommended as an option for the low back. The MTUS guidelines recommend a trial of 6 visits over 2 weeks and with evidence of objective functional improvement, a total up to 18 visits over 6 to 8 weeks. For elective/maintenance care it is not medically necessary. For recurrences/flare-ups, there is a need to re-evaluate treatment success, if return to work achieved, then 1 to visits ever 4 to 6 months. Chiropractic therapy is not recommended for the ankle or foot, carpal tunnel syndrome, forearm, wrist and hand and knee. A treatment plan to produce affect is 4 to 6 treatments with the frequency of 1 to 2 times per week the first 2 weeks as indicated by the severity of the condition. Treatment may continue at 1 treatment per week for the next 6 weeks. The maximum duration is 8 weeks. In the clinical notes provided for review, there is lack of documentation indicating the provider's rationale for the request for chiropractic therapy. It was noted that the injured worker showed objective signs of improvement with the treatment already rendered. However, it is not noted

whether the injured worker is participating in a home exercise program. Furthermore, the request does not specify state at what site the chiropractic treatment is to be performed. The retrospective request for chiropractic care once a week for 4 weeks is not medically necessary and appropriate.

PAIN MANAGEMENT REFERRAL WITH SPECIALIST: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 78.

Decision rationale: The California MTUS Guidelines state that consideration in the consultation with a multidisciplinary pain clinic; if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consultation if there is evidence of substance abuse misuse. In the clinical note provided for review, it is noted that the patient showed signs of improvement with the treatment administered. There is also a lack of the patient's pain level. The MTUS Guidelines recommend a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. The patient prior courses of treatment were not indicated within the provided documentation. Furthermore, the physical examination did not reveal any significant functional or neurological deficits to warrant a lumbar spine epidural injection. Therefore, the request for a pain management referral with specialist is not medically necessary and appropriate.

**REFERRAL TO DERMATOLOGIST FOR SKIN IRRITATION ON HER HANDS:
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) Forearm, Wrist, & Hand (Acute & Chronic), Office visits.

Decision rationale: The Official Disability Guidelines (ODG) state that office visits are recommended as determined to be medically necessary. Evaluation and management outpatient visits to the offices of medical doctors play a critical role in the proper diagnosis and return to function of an injured worker and they should be encouraged. The need for a clinical office visit with a healthcare provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability and reasonable physician judgment. Determination is also based on what medications the patient is taking, since some medicines such as opioids, or medicines such as certain antibiotics, require close monitoring. As an injured worker's conditions are extremely varied, a set number of office visits of work conditioning cannot be reasonably

established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best injured worker outcomes are achieved with eventual injured worker independence from the healthcare system through self-care as soon as clinically feasible. In the clinical notes provided for review, there is lack of evidence of the injured worker having irritation to her hands. The physical examination within the documentation provided does not address any skin abnormalities to the hands for which a consultation would be indicated. The range of motion and sensory function were the only 2 examinations documented. The injured worker also did not state that there were any concerns due to skin irritation on her hands. Therefore, the referral to dermatologist for skin irritation on the hands is not medically necessary and appropriate.

UPDATED EMG (ELECTROMYOGRAPHY) TESTING OF THE LOWER EXTREMITIES: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341-143.

Decision rationale: The MTUS/ACOEM Guidelines state that EMG are not needed to evaluate most complaints until after a period of conservative care and observation. In the clinical notes provided for review, it is noted that an EMG/NCV of the lower extremities revealed abnormal results dated on 11/29/2012; however, an official report of the results is not provided to indicate the specific findings. The documentation lacks evidence of the injured worker indicating new symptoms that would warrant an updated EMG of the lower extremities. It is also noted in the documentation that the injured worker continued to show objective signs of improvement with the treatment administered. The rationale for the request of an updated EMG is also not provided within the documentation. Therefore, the request for an updated EMG (electromyography) testing of the lower extremities is not medically necessary and appropriate.

UPDATED NCV (NERVE CONDUCTION STUDIES) TESTING OF THE LOWER EXTREMITIES: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Lumbar and Thoracic, Nerve conduction studies (NCS).

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, Lumbar and Thoracic, Nerve conduction studies (NCS).

Decision rationale: The Official Disability Guidelines (ODG) state that electronic diagnostic testing is not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Within the clinical notes provided for review, it was noted that an EMG/NCV of the lower extremities

revealed abnormal results dated on 11/29/2012; however, an official report of the results is not provided to indicate the specific findings. The documentation lacks evidence of the injured worker indicating new symptoms that would warrant an updated NCV of the lower extremities. It is also noted in the documentation that the injured worker showed objective signs of improvement with the treatment administered. Therefore, the request for updated NCV (nerve conduction studies) testing of the lower extremities is not medically necessary and appropriate.