

Case Number:	CM14-0056464		
Date Assigned:	09/10/2014	Date of Injury:	12/27/2012
Decision Date:	10/10/2014	UR Denial Date:	04/11/2014
Priority:	Standard	Application Received:	04/26/2014

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 Internal Medicine, Pulmonary Diseases 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 42-year-old female who reported an injury on December 27, 2012 reportedly while she was walking down stairs at work when she slipped on a wooden step, causing her to fall backwards and strike her low back, neck, right arm, and left knee against the stairs as she fell. The injured worker's treatment history included MRI studies of the cervical and lumbar spine, electromyogram (EMG)/nerve conduction studies (NCS), physical therapy sessions, and medications. On June 06, 2013, the injured worker underwent an MRI of the lumbar spine that revealed significant mild degenerative changes within the L5-S1 disc without protrusion or neural compression. On July 09, 2013, the injured worker underwent an EMG study of the cervical spine and upper extremity that showed no acute or chronic denervation potentials in any of the muscles tested. There was a normal NCV study of the upper extremities that did not reveal any electrophysiological evidence of peripheral nerve entrapment. The injured worker was evaluated on May 22, 2013 and it was documented the injured worker complained of pain in the neck and low back that was rated at 8/10, with loss of appetite and decreased muscle mass and strength. She stated she had difficulty with activities of daily living. The pain was worse with repetitive motions as well as cold weather. Objective findings included positive Kemp's test indicating possible facet pain in the low back, decreased lumbar spine extension and lateral bending, as well as tenderness, muscle guarding, and spasm from L3-S1. Additionally, palpation revealed radiation to the left lower extremity. Diagnoses included lumbar spine intervertebral disc (IVD) syndrome, rule out with associate complaint of pain affecting the leg, and lumbar sprain/strain. The Request for Authorization dated June 10, 2013 was for extended rental of neurostimulator TENS/EMS.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request of Extended rental of Neuro-stimulator Transcutaneous Electrical Nerve Stimulation-Electrical Muscle Stimulator-12 months for DOS 5/22/13: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of TENS Page(s): 116.

Decision rationale: The request for retrospective of extended rental of Neuro-stimulator Transcutaneous Electrical Nerve Stimulation Muscle Stimulator 12-months for DOS 05/22/2013 is not medically necessary. Per the Chronic Pain Medical Treatment Guidelines (MTUS) states that the Electrical Muscle Stimulation Unit it not recommend for chronic pain. It states that the Electrical Muscle Stimulation Unit should not be used as a primary treatment modality, but a one month home based Electrical Muscle Stimulation trial may be considered as a noninvasive conservative option, if used as (an adjunct to ongoing treatment modalities within functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial. There was no mention of any clinical trial the Electrical Muscle Stimulation Unit resulting on the functional improvements establishing efficacy of this device for the injured worker. There is lack of documentation to support the injured worker conservative care, including active modalities, such as physical therapy. In addition, the request does not specify location where the Electrical Muscle Stimulation Unit will be used on the injured worker. Given the above request is not medically necessary.

Retrospective request for 8 Electrical Stimulation Therapy Treatments for DOS 5/22/13: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of TENS Page(s): 116.

Decision rationale: The request for retrospective 8 Electrical Stimulation Therapy Treatments for DOS 05/22/2013 is not medically necessary. Per the Chronic Pain Medical Treatment Guidelines (MTUS) states that the Electrical Muscle Stimulation Unit it not recommend for chronic pain. It states that the Electrical Muscle Stimulation Unit should not be used as a primary treatment modality, but a one month home based Electrical Muscle Stimulation trial may be considered as a noninvasive conservative option, if used as (an adjunct to ongoing treatment modalities within functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial. There was lack of documentation resulting on the functional improvements establishing efficacy for the injured worker. There is lack of documentation to

support the injured worker conservative care, including active modalities, such as physical therapy. Given the above request is not medically necessary.

Retrospective request for Neurostimulator TENS-EMS for DOS 5/22/13: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation (NMES devices) Page(s): 121.

Decision rationale: The requested is not medically necessary. Per California Medical Treatment Utilization Schedule (MTUS) Guidelines, state NMES is not recommended. NMES is used primarily as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. There are no intervention trials suggesting benefit from NMES for chronic pain. The scientific evidence related to electromyography (EMG)-triggered electrical stimulation therapy continues to evolve, and this therapy appears to be useful in a supervised physical therapy setting to rehabilitate atrophied upper extremity muscles following stroke and as part of a comprehensive PT program. Neuromuscular Electrical Stimulation Devices (NMES), NMES, through multiple channels, attempts to stimulate motor nerves and alternately causes contraction and relaxation of muscles, unlike a TENS device which is intended to alter the perception of pain. NMES devices are used to prevent or retard disuse atrophy, relax muscle spasm, increase blood circulation, maintain or increase range-of-motion, and re-educate muscles. The documents submitted indicated the injured worker has had prior physical therapy however, the outcome measurements were not submitted for review. As such, the request for retrospective for Neurostimulator TENS -EMS for DOS 05/22/2013 is not medically necessary.

Retrospective request for 8 Traction, Mechanical therapy treatments for DOS 5/22/13: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Lumbar & Thoracic. Powered Traction Devices.

Decision rationale: The request for retrospective 8 traction, mechanical therapy treatments for DOS 05/22/2013 is not medically necessary. According to the California MTUS/ACOEM Practice Guidelines, traction has not been proved effective for lasting relief in treating low back pain. However, as these Guidelines do not address the use of traction in the chronic state, the Official Disability Guidelines (ODG) stated power traction devices are not recommended but home based patient controlled gravity may be a noninvasive conservative option if used as an adjunct to a program of evidence based conservative care. Traction as a sole treatment has not been approved for lasting relief in the treatment of low back pain. Power traction devices are not

recommended. As such, the request for 8 traction, mechanical therapy treatments is not medically necessary.

Retrospective request for 8 Chiropractic Manipulative therapy treatments for DOS 5/22/13: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back-Lumbar & Thoracic (Acute & Chronic)

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

Decision rationale: The requested is not medically necessary. The California MTUS Guidelines may support up to 18 visits of chiropractic sessions Manual Therapy & Manipulation is recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. The documents submitted stated the injured worker attended physical therapy sessions however, the outcome measurements or long-term functional goals were not provided. There was home exercise regimen for the injured worker. Given the above, the request for retrospective 8 Chiropractic Manipulative Therapy treatments for DOS 05/22/2013 is not medically necessary.

Retrospective request for Lumbar Spine Support for DOS 5/22/13: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298, 301.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

Decision rationale: The request for retrospective lumbar spine support for DOS 05/22/2013 is not medically necessary. California MTUS/ACOEM Practice Guidelines states that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. The documents submitted on May 22, 2013 indicated the injured worker had been provided the lumbar spine support however, the guidelines do not recommend this option as beneficial beyond the acute phase of symptom relief. There is no rationale provided to warrant the request for a lumbar back brace. Given the above, the request is not medically necessary.

Retrospective request for MRI of Lumbar Spine for DOS 5/22/13: Upheld

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

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

Decision rationale: The request for retrospective Magnetic Resonance Images of the Lumbar Spine for DOS 05/22/2013 is not medically necessary. ACOEM Practice Guidelines recommend imaging studies when physiologic evidence identifies specific nerve compromise on the neurologic examination. The rationale for the request was to re-evaluate and rule out a lumbar disc syndrome. It was also documented the injured worker obtained a MRI 06/06/2013 that revealed significant for mild degenerative changes within the L5-S1 disc without disc protrusion or neural compression. However, the request for DOS is 05/22/2013 it is not clear when she received the MRI. Furthermore, the injured worker's physical examination findings are consistent with no change his current diagnosis. There is a lack of objective findings identifying specific nerve compromise to warrant the use of imaging. There is a lack of documentation to verify the failure of conservative measures. There is also no indication of red flag diagnoses or the intent to undergo surgery. Given the above, the request is not medically necessary.

Retrospective request for EMG of the Bilateral lower extremity for DOS 5/22/13: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic)

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

Decision rationale: The request for retrospective electromyogram of the bilateral lower extremities for DOS 05/22/2013 is not medically necessary. The California MTUS/ACOEM Practice Guidelines do not recommend electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than 3 weeks or 4 weeks. The Official Disability Guidelines recommend electromyography as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1 month conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious. There was a normal EMG studies done on 07/09/2013. However the request was for DOS 05/22/2013. It is unclear when the EMG study was done. There was no mentioned of a home exercise regimen outcome. In addition, the injured worker has no documented evidence per the physical examination done on 05/22/2013 indicating nerve root dysfunction. Given the above, the request is not medically necessary.

Retrospective request for NCV of the bilateral lower extremity for DOS 5/22/13: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic)

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. Nerve

Decision rationale: The request retrospective nerve conduction study of the bilateral lower extremity for DOS 05/22/2013 is not medically necessary. The Official Disability Guidelines do not recommend NCV studies, as there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. This systematic review and meta-analysis demonstrate that neurological testing procedures have limited overall diagnostic accuracy in detecting disc herniation with suspected radiculopathy. In the management of spine trauma with radicular symptoms, EMG/nerve conduction studies (NCS) often have low combined sensitivity and specificity in confirming root injury and there is limited evidence to support the use of often uncomfortable and costly EMG/NCS. The injured worker had a normal NCV study on 07/09/2013. The request submitted indicated DOS 05/22/2013 it is unclear when the NCV study was done. There was no mentioned of a home exercise regimen outcome. Given the above, the request for nerve conduction study of is not medically necessary.

Retrospective request for Orthopedic Consultation for DOS 5/22/13: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 289, 296, 305.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Office Visits.

Decision rationale: The request for retrospective for Orthopedic Consultation for DOS 05/22/2013 is not medically necessary. Per the Official Disability Guidelines (ODG), office visits are recommended based on patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. There was no indication of failed conservative care to warrant a consult for an Orthopedic Consultation. Given the above, the request for is not medically necessary.