MAXIMUS Federal Services

Case Number:	CM14-0059245		
Date Assigned:	05/02/2014	Date of Injury:	03/19/2012
Decision Date:	08/15/2014	UR Denial Date:	12/31/2013
Priority:	Standard	Application Received:	01/31/2014

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 28-year-old female who has filed a claim for lumbosacral musculoligamentous injury associated with an industrial injury date of March 19, 2012. A review of progress notes from May 02, 2013 and earlier indicates lumbar spine pain with occasional urinary incontinence; neck pain radiating to the bilateral upper extremities, with numbness and tingling; headaches; bilateral shoulder pain; and pain, weakness, and numbness of both hands. Findings include tenderness over the cervical and lumbar regions; positive Spurling's test; positive Tinel's in both wrists and Phalen's to the right; decreased sensation over the right median nerve distribution, proximal medial thighs, and right L4-S1 distributions; decreased motor strength of the right hip flexors, knee extensors and flexors, and ankle dorsiflexors and plantarflexors; decreased reflexes of the right lower extremity; and positive straight leg raise test on the right. Cervical MRI dated March 06, 2013 showed disc desiccation at C3-4 through C6-7 without evidence of foraminal encroachment or spinal stenosis. Lumbar MRI showed mild disc degeneration at L5-S1 with disc protrusion resulting in mild effacement of the ventral subarachnoid space; and a curvilinear fissure at L5-S1. Neurodiagnostic study dated October 04, 2012 showed moderate right carpal tunnel syndrome; and moderate L4, L5, S1 polyradiculopathy on the right and slight-moderate L5 and S1 nerve root compression on the left. Treatment to date has included acupuncture, opioids, NSAIDs, Gabapentin, muscle relaxants, sedatives, chiropractic therapy, and topical analgesics. Utilization review from December 31, 2013 denied the retrospective requests for acupuncture as there was no documentation of improvement with previous sessions; spinal surgeon consultation, LSO brace, 30-day trial of H-wave, and wrist splint as these were previously certified; neurodiagnostic studies as a repeat study is not necessary; pain management consultation as there was no consistent documentation of radiculopathy at a specific level and Ultracet as there was no documentation of efficacy.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE ACUPUNCTURE BETWEEN 5/2/2013 AND 12/20/2013: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Pain, Suffering, and the Restoration of Function chapter, page 114.

Decision rationale: As noted on page 114 of the California 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 that the patient had 3 acupuncture sessions to the cervical region, with no documentation of improvement in symptoms or function. Although up to 6 sessions is recommended for functional improvement, the requested number of sessions and body part are not indicated. Therefore, the retrospective request for acupuncture was not medically necessary.

RETROSPECTIVE SPINAL SURGEON CONSULTATION BETWEEN 5/2/2013 AND 10/20/2013: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Independent Medical Examinations and Consultations chapter, pages 127 and 156.

Decision rationale: As stated on pages 127 and 156 of the ACOEM Independent Medical Examinations and Consultations Guidelines referenced by California MTUS, occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. In this case, the patient presents with low back pain with occasional urinary incontinence and examination findings of neurologic deficits consistent with nerve compression.

Although there were no correlating findings on lumbar MRI from March 06, 2013, the patient's worsening lumbar spinal condition warrants a consultation with spinal surgeon. Previous utilization review determination, dated January 03, 2014, has already certified this request for consultation between 6/13/2013 and 12/20/2103. Therefore, the retrospective request for spinal surgeon consultation is not medically necessary.

RETROSPECTIVE NEURODIAGNOSTIC STUDIES OF NECK AND BILATERAL UPPER EXTREMITIES BETWEEN 5/2/2013 AND 12/20/2013: Upheld

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 10 Elbow Disorders (Revised 2007) Page(s): 238. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back chapter, Electromyography (EMG); Nerve conduction studies (NCS).

Decision rationale: California MTUS criteria for EMG/NCV of the upper extremity include documentation of subjective/objective findings consistent with radiculopathy/nerve entrapment that has not responded to conservative treatment. ODG states that electromyography findings may not be predictive of surgical outcome and cervical surgery, and patients may still benefit from surgery even in the absence of EMG findings of nerve root impingement. EMG may be helpful for patients with double crush phenomenon, possible metabolic pathology such as with diabetes or thyroid disease, or evidence of peripheral compression such as carpal tunnel syndrome. Nerve conduction studies are not recommended to demonstrate radiculopathy if it has already been clearly identified by EMG and obvious clinical signs. It is recommended if EMG does not show clear radiculopathy, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if the diagnosis may be likely based on the clinical exam. Previous utilization review dated January 01, 2014 indicated that the requesting physician intended to rule out carpal tunnel syndrome. In this case, the patient had a neurodiagnostic study of the upper extremities dated October 04, 2012 showed moderate right carpal tunnel syndrome. There is no documentation regarding significant changes in the patient's neck and upper extremity symptoms at that time to support a repeat neurodiagnostic study. Therefore, the request for neurodiagnostic studies of neck and upper extremities was not medically necessary.

RETROSPECTIVE REQUEST FOR ONE PAIN MANAGEMENT CONSULTATION BETWEEN 5/2/2013 AND 12/20/2013:

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Independent Medical Examinations and Consultations chapter, pages 127 and 156.

Decision rationale: As stated on pages 127 and 156 of the ACOEM Independent Medical Examinations and Consultations Guidelines referenced by California MTUS, occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. The requesting physician indicates that a consultation with pain management is necessary for lumbar epidural. As stated on page 46 of CA MTUS Chronic Pain Medical Treatment Guidelines, there is no support for epidural injections in the absence of objective radiculopathy. Criteria for the use of epidural steroid injections include an imaging study documenting correlating concordant nerve root pathology and conservative treatment. In this case, imaging study did not show any significant nerve root impingement, which is in contrast to the patient's presentation of lower extremity motor and sensory deficit with complaints of low back pain and occasional urinary incontinence. There is no clear indication of lumbar radiculopathy to support a consultation of epidural injection. Therefore, the retrospective request for pain management consultation was not medically necessary.

RETROSPECTIVE REQUEST FOR ONE WRIST SPLINT BETWEEN 5/2/2013 AND 12/20/2013: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 264-265.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Carpal Tunnel Syndrome chapter, Splinting.

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 was used instead. According to ODG, splinting of the wrist in neutral position at night is recommended as an option in conservative treatment. Use of daytime splints has positive, but limited evidence. In this case, the patient presented with bilateral hand pain, weakness, and numbness, with examination and neurodiagnostic findings consistent with right carpal tunnel syndrome. Use of a wrist splint is medically necessary for conservative management of this condition. Therefore, the request for wrist splint is not medically necessary.

RETROSPECTIVE REQUEST FOR ONE LSO BRACE BETWEEN 5/2/2013 AND 12/20/2013: 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 based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back chapter, Lumbar supports.

Decision rationale: As stated on page 301 of the ACOEM Low Back Guidelines referenced by CA MTUS, back braces have not been shown to have any lasting benefit beyond the acute phase

of symptom relief. According to ODG, they are indicated for management of compression fractures, spondylolisthesis, or documented instability. There is very low quality evidence for treatment of nonspecific LBP as a conservative option. Lumbar supports are not recommended for prevention. In this case, there is no documentation supporting the presence of lumbar instability in this patient. Therefore, the retrospective request for LSO brace was not medically necessary.

RETROSPECTIVE 30 DAY TRIAL OF H-WAVE UNIT BETWEEN 5/2/2013 AND 12/20/2013: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : Transcutaneous electrotherapy, H-wave stimulation (HWT) Page(s): 117-118.

Decision rationale: According to CA MTUS Chronic Pain Medical Treatment Guidelines pages 117-118, H-wave therapy is not recommended as an isolated intervention, but a one-month home-based trial of H-Wave stimulation may be considered as a noninvasive conservative option for chronic soft tissue inflammation if used as an adjunct to a program of evidence-based functional restoration following failure of initially recommended conservative care, including recommended physical therapy, medications, and transcutaneous electrical nerve stimulation (TENS). In this case, there is no documentation that the patient had previous TENS therapy. Also, utilization review dated January 01, 2014 noted that this request was previously certified in 3/6/2013 for a time period between 2/20/2013 and 12/20/2013. Therefore, the retrospective request for 30 day trial of H-wave unit was not medically necessary.

RETROSPECTIVE REQUEST FOR ONE ULTRACET BETWEEN 5/2/2013 AND 12/20/2013: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use; On-Going Management Page(s): 78-82.

Decision rationale: As noted on pages 78-82 of the CA MTUS Chronic Pain Medical Treatment Guidelines, there is no support for ongoing opioid treatment unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In this case, there is no documentation that the patient has been started on this medication. Progress report from March 21, 2013 indicates that the patient is on Norco. There is no indication as to why an additional opioid medication is necessary, as there was mention that the patient desires to cut down on oral pain medications. Therefore, the retrospective request for Ultracet was not medically necessary.