

Case Number:	CM14-0215786		
Date Assigned:	02/11/2015	Date of Injury:	09/08/2014
Decision Date:	04/01/2015	UR Denial Date:	12/09/2014
Priority:	Standard	Application Received:	12/23/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 51-year-old male, who sustained an industrial injury on September 8, 2014. The diagnoses have included lumbar spine sprain/strain and left shoulder strain/sprain. Treatment to date has included Magnetic resonance imaging of the left shoulder and pain medications. Currently, the injured worker complains of left shoulder and back pain. In a progress note dated October 2, 2014, the treating provider reports moderate tenderness to cervical spine, and bilateral sacroiliac joints his gait was minimal antalgic both feet. On December 9, 2014 Utilization Review non-certified a Magnetic resonance imaging of lumbar spine with intravenous contrast, electromyogram right upper extremity, electromyogram left upper extremity, nerve conduction study of right upper extremity, electromyogram of left lower extremity, nerve conduction study of left lower extremity, nerve conduction study of right lower extremity, physical therapy two times week for six weeks lumbar spine and left shoulder and Kera-Tek gel four ounces, noting, Medical Treatment Utilization Schedule Guidelines, American College of Occupational and Environmental Medicine and Official Disability Guidelines was cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the Lumbar Spine with Intravenous Contrast: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines.

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 & Thoracic (Acute & Chronic), MRIs (magnetic resonance imaging).

Decision rationale: The claimant sustained a work injury in September 2014 with injury to the low back and left shoulder/arm. His past medical history included lumbar spine surgery in 2002. When seen by the requesting provider, treatment had consisted of Norco, which caused constipation and occasional abdominal pain. He had not received any other treatments. Physical examination findings included positive left straight leg raising. He had decreased lower extremity strength and sensation. He had decreased left upper extremity sensation affecting the median and ulnar nerves. Applicable criteria for obtaining an MRI would include a history of trauma with neurological deficit, when there are 'red flags' such as suspicion of cancer or infection, or when there is radiculopathy with severe or progressive neurologic deficit. In this case, there are no identified 'red flags' that would support the need for obtaining an MRI scan, which therefore was not medically necessary.

EMG/NCV of the Bilateral Upper Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (1) Carpal Tunnel Syndrome (Acute & Chronic), Electrodiagnostic studies (EDS) (2) Carpal Tunnel Syndrome (Acute & Chronic), Splinting and Other Medical Treatment Guidelines Pain (Chronic), Electrodiagnostic testing (EMG/NCS) AANEM Recommended Policy for Electrodiagnostic Medicine.

Decision rationale: The claimant sustained a work injury in September 2014 with injury to the low back and left shoulder/arm. His past medical history included lumbar spine surgery in 2002. When seen by the requesting provider, treatment had consisted of Norco, which caused constipation and occasional abdominal pain. He had not received any other treatments. Physical examination findings included and a positive left straight leg raising. He had decreased lower extremity strength and sensation. He had decreased left upper extremity sensation affecting the median and ulnar nerves. Electrodiagnostic testing (EMG/NCS) is generally accepted, well-established and widely used for localizing the source of the neurological symptoms and establishing the diagnosis of focal nerve entrapments, such as carpal tunnel syndrome or radiculopathy. Nerve conduction testing is recommended in patients with clinical signs of CTS who may be candidates for surgery. Criteria include that the testing be medically indicated. In this case, the claimant has not undergone a trial of conservative treatments and is not a surgical candidate. Therefore, this requested is not medically necessary.

EMG/NCV of the Bilateral Lower Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines.

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 & Thoracic (Acute & Chronic), Nerve conduction studies (NCS).

Decision rationale: The claimant sustained a work injury in September 2014 with injury to the low back and left shoulder/arm. His past medical history included lumbar spine surgery in 2002. When seen by the requesting provider, treatment had consisted of Norco, which caused constipation and occasional abdominal pain. He had not received any other treatments. Physical examination findings included positive left straight leg raising. He had decreased lower extremity strength and sensation. He had decreased left upper extremity sensation affecting the median and ulnar nerves. Nerve conduction studies (NCS) for lumbar radiculopathy are not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of lumbar radiculopathy. Therefore, the requested bilateral lower extremity NCV with EMG was not medically necessary. Low Back-Lumbar & Thoracic (Acute & Chronic), Nerve conduction studies (NCS).

Physical Therapy 2 x 6, for the Lumbar Spine, Left Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (1) Low Back - Lumbar & Thoracic (Acute & Chronic) Physical therapy (2) Shoulder (Acute & Chronic) Physical therapy.

Decision rationale: The claimant sustained a work injury in September 2014 with injury to the low back and left shoulder/arm. His past medical history included lumbar spine surgery in 2002. When seen by the requesting provider, treatment had consisted of Norco, which caused constipation and occasional abdominal pain. He had not received any other treatments. Physical examination findings included positive left straight leg raising. He had decreased lower extremity strength and sensation. He had decreased left upper extremity sensation affecting the median and ulnar nerves. Physical therapy treatment for the claimant's conditions would be expected to include up to 10 visits over eight weeks for the shoulder and 10 visits over eight weeks for the lumbar spine. In this case, Concurrent treatment would be expected and therefore, the number of visits requested is in excess of guidelines recommendations and not medically necessary.

Kera-Tek gel, 4oz: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (1) Medications for chronic pain, p60 (2) Topical Analgesics, p111-113 Page(s): 60, 111-113.

Decision rationale: The claimant sustained a work injury in September 2014 with injury to the low back and left shoulder/arm. His past medical history included lumbar spine surgery in 2002. When seen by the requesting provider, treatment had consisted of Norco, which caused constipation and occasional abdominal pain. He had not received any other treatments. Physical examination findings included positive left straight leg raising. He had decreased lower extremity strength and sensation. He had decreased left upper extremity sensation affecting the median and ulnar nerves. The active ingredients of Kera-tek gel are menthol and methyl salicylate. Menthol and methyl salicylate are used as a topical analgesic in over the counter medications such as Ben-Gay or Icy Hot. Guidelines recommend that when prescribing medications only one medication should be given at a time. By prescribing a multiple combination medication, in addition to the increased risk of adverse side effects, it would not be possible to determine whether any derived benefit is due to a particular component. Therefore, the Kera-tek gel was not medically necessary.