

Case Number:	CM15-0009452		
Date Assigned:	01/27/2015	Date of Injury:	05/24/2011
Decision Date:	04/07/2015	UR Denial Date:	12/19/2014
Priority:	Standard	Application Received:	01/16/2015

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: New York

Certification(s)/Specialty: Emergency Medicine

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 (IW) is a 44-year-old male who sustained an industrial injury reported on 5/24/2011. He has reported constant, radiating, sharp pain in the lumbar spine, burning pain in the left knee, constant pain and weakness in the left ankle, and numbness in the left shoulder. The diagnoses have included lumbar spine sprain/strain; left should sprain/strain; and left knee and ankle sprain/strain. Treatments to date have included consultations, diagnostic imaging studies, nerve conduction studies, physical therapy/rehabilitation treatments, braces/stabilizers, and medication management. The work status classification for this injured worker (IW) was noted to be returned to work with restrictions. On 12/18/2014 Utilization Review (UR) non-certified, for medical necessity, the request made on 12/17/2014, for physical therapy 3 x a week x 3 weeks; magnetic resonance imaging of the cervical and lumbar spine and left ankle; and electromyogram with nerve conduction studies of the bilateral upper and lower extremities. The Medical Treatment Utilization Schedule, chronic pain medical treatment, physical medicine; along with the American College of Occupational and Environmental Medicine and Official Disability Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy (3 times per week for 3 weeks for the Lumbar Spine): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines Page(s): 98 and 99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: CA MTUS chronic pain guidelines for manual therapy and manipulation are used in support of this decision. It is assumed this request is for ongoing physical therapy for a chronic condition. Documentation does not include the number of previous physical therapy treatments or any measure of functional improvement resulting from these treatments. Other conservative treatments with the exception of medications are not included in the chart materials. The IW has return to work with modifications. Previous pain medications have been renewed without any mention of decreasing dosing or frequency. Guidelines do not recommend maintenance care and the IW should have a home, independent program as guidelines support "fading of treatment frequency along with active self-directed home PT." There is no mention of a home PT program in the records. The request for PT is not medically necessary.

MRI Cervical Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 172 and 182. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-TWC, Neck and Upper Back Procedure Summary.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 172-173. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back.

Decision rationale: CA MTUS ACOEM guidelines recommends imaging studies for cases "in which surgery is considered or red-flag diagnoses are being evaluated." With respect to cervical magnetic resonance imaging studies, other indications include neck, shoulder, posterior arm pain or paresthasias or postlaminectomy syndrome. ODG guidelines recommend an MRI for the following indications only "Chronic neck pain (after 3 months conservative treatment), radiographs normal, neurologic signs or symptoms present; Neck pain with radiculopathy if severe or progressive neurologic deficit; Chronic neck pain, radiographs show spondylosis, neurologic signs or symptoms present; Chronic neck pain, radiographs show old trauma, neurologic signs or symptoms present; Chronic neck pain, radiographs show bone or disc margin destruction; Suspected cervical spine trauma, neck pain, clinical findings suggest ligamentous injury sprain), radiographs and/or CT "normal"; Known cervical spine trauma: equivocal or positive plain films with neurological deficit; Upper back/thoracic spine trauma with neurological deficit." The IW does not have any of these indications. An assessment dates 10/16/2014 refers to a previous cervical MRI, but does not discuss the indications or results. This report does not list any diagnoses related to the cervical spine and there is no mention on the record that the IW experienced cervical trauma. In the absence of appropriate indications or physical exam findings, the request for a cervical MRI is not medically necessary.

MRI Lumbar Spine: 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 (ODG)-TWC, Low Back Procedure Summary.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back.

Decision rationale: CA MTUS ACOEM guidelines recommends imaging studies for cases "in which surgery is considered or red-flag diagnoses are being evaluated." ODG guidelines state "repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology." The IW has previously had a lumbar MRI. Documentation does not support significant changes in subjective complaints of objective findings. There is not documentation of new injuries or adjustments to analgesic medication. In the absence of supporting documentation of a new injury or progressive symptoms, the request for a lumbar MRI is not medically necessary.

MRI Left Ankle: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 372-373. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-TWC, Ankle & Foot Procedure Summary.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 372-374. Decision based on Non-MTUS Citation Foot & Ankle.

Decision rationale: CA MTUS ACOEM guidelines recommend MRI of the ankle or foot to "help clarify a diagnosis such as osteochondritis dissecans in a case of delayed recovery." According to ODG guidelines, lists several indications for MRI. These guidelines also states "Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology." A medical report dated 10/16/2014 mentions a previously completed MRI of the left ankle. The imaging study report or discussion of findings is not included in the documentation submitted. Examination findings on this same date of service reveal a nearly normal exam. There is no mention of new injury or concern for progressive pathology. Additionally, there is reference to evaluation by an orthopedic provider, but no detailed plans for surgery or proposed management is included for review. Without this supporting documentation, the request for a left ankle MRI is not medically necessary.

EMG/NCV Bilateral Upper Extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178 and 182. Decision based on Non-MTUS Citation Official Disability Guidelines(ODG)-TWC, Neck and Upper Procedure Summary.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Upper Neck & Back.

Decision rationale: CA MTUS ACOEM guidelines recommend EMG testing to "clarify nerve root dysfunction in cases of suspected disk herniation pre-operatively or before epidural injections. The ODG guidelines recommend the study for specific cases including a positive diagnoses of radiculopathy. This requirement includes "Requires the identification of neurogenic abnormalities in two or more muscles that share the same nerve root innervation but differ in their peripheral nerve supply." The indications for EMG testing are not included in chart materials. There is not documentation of subjective or objective findings of radiculopathy. Moreover, there is not documentation to support bilateral upper extremity testing. Without this, the request for bilateral upper extremity EMG testing is not medically necessary.

EMG-NCV Bilateral Lower Extremity: 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 (ODG)-TWC, Low Back Procedure Summary.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back.

Decision rationale: CA MTUS guideline recommend EMG studies for evaluation of disk protrusion, cauda equina syndrome, spinal stenosis and post laminectomy syndrome. According to ODG guidelines, EMG studies are "recommended as an option (needle, not surface). EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious." Furthermore, documentation states "surface EMG and F-wave tests are not very specific and therefore are not recommended." Documentation does not provide a rationale for the requested testing or why it is bilateral. Subjective and objective history does not support radicular symptoms. The request does not specify if the requested tests are surface or needle studies. Without this clarification and supporting documentation, the request is not medically necessary.