

Case Number:	CM15-0109644		
Date Assigned:	06/09/2015	Date of Injury:	05/28/2013
Decision Date:	07/10/2015	UR Denial Date:	04/28/2015
Priority:	Standard	Application Received:	05/15/2015

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: Pennsylvania
 Certification(s)/Specialty: Internal 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:

This 28 year old female sustained an industrial injury on 5/28/13 due to continuous trauma. Diagnoses include brachial neuritis/ radiculopathy and cervicgia. Treatments to date include medications. An emergency room visit for medication refill from 12/1/14 notes that the injured worker has seen an orthopedic surgeon with MRI showing a bulging disc. Reports from the treating physician from January to April 2015 indicate that the injured worker continues to experience neck pain. Upon examination, there is tenderness in the occiput, with decreased cervical spine range of motion noted. Deep tendon reflexes were symmetric at biceps, triceps and brachioradialis. Motor power is 5/ 5. Work status was noted as modified duty with restrictions. A request for Physical therapy x 8 cervical spine, Acupuncture x 6 for the cervical spine, MRI of the cervical spine, EMG (electromyography)/NCV (nerve conduction velocity) of the bilateral upper extremities, Heating pad purchase and IF unit purchase was made by the treating physician. The Utilization Review determination refers to a report from 4/30/14, which states that the injured worker had undergone chiropractic care and physical therapy; this report was not submitted and no physical therapy treatment notes were submitted. On 4/28/15, Utilization Review (UR) non-certified requests for the items currently under Independent Medical Review, citing the MTUS, ACOEM, and ODG.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy x 8 cervical spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter: physical medicine treatment.

Decision rationale: This injured worker has chronic neck pain. Physical medicine is recommended by the MTUS with a focus on active treatment modalities to restore flexibility, strength, endurance, function, and range of motion, and to alleviate discomfort. The ODG states that patients should be formally assessed after a six visit clinical trial to evaluate whether physical therapy has resulted in positive impact, no impact, or negative impact prior to continuing with or modifying the physical therapy. Both the MTUS and ODG note that the maximum number of sessions for unspecified myalgia and myositis is 9-10 visits over 8 weeks, and 8-10 visits over 4 weeks for neuralgia, neuritis, and radiculitis. The Utilization Review determination refers to a progress report that indicates that this injured worker had prior physical therapy; however, the submitted documentation does not mention physical therapy and no treatment notes, dates of treatment, or results were submitted. There was no documentation of functional improvement from any prior physical therapy to support additional treatment. If this request is interpreted as an initial request, the number of sessions requested (8) is in excess of the guideline recommendations for a six visit clinical trial. The records do not contain a sufficient prescription from the treating physician, which must contain diagnosis, duration, frequency, and treatment modalities, at a minimum. A non-specific prescription for "physical therapy" in cases of chronic pain is not sufficient. Reliance on passive care is not recommended. The physical medication prescription is not sufficiently specific, and does not adequately focus on functional improvement. No functional goals were discussed. Per the MTUS chronic pain section, functional improvement is the goal rather than the elimination of pain. Due to number of sessions requested in excess of the recommended initial trial, and lack of sufficiently specific prescription, the request for physical therapy is not medically necessary.

Acupuncture x 6 for the cervical spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: Per the MTUS, acupuncture is 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. The MTUS recommends an initial trial of 3-6 visits of acupuncture. Frequency of treatment of 1-3 times per week with an optimum duration of 1-2 months is specified by the MTUS. Medical necessity for any further acupuncture is considered in light of functional improvement. Acupuncture treatments may be extended if functional

improvement is documented. This injured worker has chronic neck pain. There was no documentation of reduction of medication or intolerance to medication, current participation in a physical rehabilitation program, or surgical intervention. Due to lack of specific indication, the request for acupuncture is not medically necessary.

MRI of the cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 172. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back, Indications for MRI (magnetic resonance imaging).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 170-172, 177-179, 182. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck and upper back chapter: MRI.

Decision rationale: This injured worker has chronic neck pain. Per the MTUS/ACOEM, for most patients presenting with neck or upper back problems, special studies are not needed unless a 3-4 week period of conservative care and observation fails to improve symptoms. Criteria for ordering imaging studies include emergence of a red flag, or physiologic evidence of tissue insult or neurologic dysfunction, and prior to an invasive procedure. Physiologic evidence may be in the form of neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. This injured worker had no objective evidence of any of these conditions or indications for an invasive procedure. The treating physician has not documented any specific neurological deficits or other signs of significant pathology. The documentation submitted refers to a prior MRI which showed a herniated disc; the date of the MRI and the report were not submitted. The ODG states that repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology, such as tumor, infection, fracture, neurocompression, or recurrent disc herniation. There was no documentation of reinjury or change in clinical condition. Due to lack of specific indication, the request for MRI of the cervical spine is not medically necessary.

EMG (electromyography)/NCV (nerve conduction velocity) of the bilateral upper extremities: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): ch 8 p. 168-171, 182, ch 11 p. 268-269, 272. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck and upper back chapter: EMG, nerve conduction studies.

Decision rationale: The ACOEM recommends EMG (electromyogram) to clarify nerve root dysfunction in cases of suspected disk herniation preoperatively or before epidural steroid

injection. Nerve conduction velocity (NCV) is recommended for median or ulnar impingement at the wrist after failure of conservative treatment. The ODG notes that EMG is moderately sensitive in relation to cervical radiculopathy. Nerve conduction studies are not recommended to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but recommended if the EMG does not clearly demonstrate radiculopathy or is clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely based on the clinical exam. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy. While cervical electrodiagnostic studies are not necessary to demonstrate a cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality, diabetic neuropathy, or some problem other than a cervical radiculopathy, with caution that these studies can result in unnecessary over treatment. There are no reports from the prescribing physician which adequately describe neurologic findings that necessitate electrodiagnostic testing. Non-specific pain or paresthesias are not an adequate basis for performance of EMG or NCV. Medical necessity for electrodiagnostic testing is established by a clinical presentation with a sufficient degree of neurologic signs and symptoms to warrant such tests. The MTUS, per the citations listed above, outlines specific indications for electrodiagnostic testing, and these indications are based on specific clinical findings. The physician should provide a diagnosis that is likely based on clinical findings, and reasons why the test is needed. The clinical evaluation is minimal and there is no specific neurological information showing the need for electrodiagnostic testing. Based on the current clinical information, EMG (electromyography)/NCV (nerve conduction velocity) of the bilateral upper extremities is not medically necessary, as the treating physician has not provided the specific indications and clinical examination outlined in the MTUS.

Heating pad purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173-174. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back, Heat/cold applications.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 44, 48-49. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck and upper back chapter: heat/cold applications.

Decision rationale: This injured worker has chronic neck pain. Both the MTUS and ODG recommend at-home local applications of cold packs in the first few days of acute complaint and thereafter applications of heat packs or cold packs. There is no recommendation for any specific device in order to accomplish this. There was lack of documentation to indicate the frequency of use of the device, and no end point to use was specified. In addition, there was no documentation as to why at-home application of hot packs would be insufficient. As such, the request for heating pad purchase is not medically necessary.

IF unit purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, Interferential Current Stimulation (ICS) Page(s): 118-120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines transcutaneous electrotherapy Page(s): 114-121.

Decision rationale: This injured worker has chronic neck pain. The MTUS for Chronic Pain provides very limited support for interferential treatment, notes the poor quality of medical evidence in support of interferential stimulation therapy, and states that there is insufficient evidence for using interferential stimulation for wound healing or soft tissue injury. Per the MTUS, interferential current stimulation is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments including return to work, exercise, and medications. In this case, work status was noted as modified work with restrictions, but the treating physician has not documented whether the injured worker has returned to work. There was no documentation of current participation in an exercise program. There are no standardized protocols for the use of interferential stimulation. If certain criteria are met, a one month trial may be appropriate to permit the physician and physical medicine provider to determine effects and benefits. Criteria include pain which is ineffectively controlled by medications, history of substance abuse, pain from postoperative conditions that limit the ability to perform exercise programs, or lack of response to conservative measures. None of these criteria were documented to be present for this injured worker. The treating physician has not provided a treatment plan which includes interferential stimulation therapy in the context of the recommendations of the MTUS. There was no documentation of a one month trial of interferential stimulation to support purchase of a unit. Due to lack of indication and lack of a treatment plan consistent with the guideline recommendations, the request for IF unit purchase is not medically necessary.