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| Case Number: | CM15-0138421 | | |
| Date Assigned: | 07/28/2015 | Date of Injury: | 05/28/2014 |
| Decision Date: | 09/16/2015 | UR Denial Date: | 06/16/2015 |
| Priority: | Standard | Application Received: | 07/16/2015 |

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: Connecticut, California, Virginia
 Certification(s)/Specialty: Preventive Medicine, Occupational 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 is a 49-year-old female, who sustained an industrial injury on 5/28/2014. The mechanism of injury was a cumulative injury. The injured worker was diagnosed as having cervical and thoracic musculoligamentous sprain/strain, lumbar and right sacroiliac joint sprain with bilateral lower extremities radiculitis and prior lumbosacral laminectomy and fusion, periscapular strain/impingement and bilateral forearm wrist tenosynovitis. There is no record of a recent diagnostic study. Treatment to date has included physical therapy and medication management. In a progress note dated 6/3/2015, the injured worker complains of pain in the neck, mid/low back pain and stiffness with right sided low back pain and numbness and tingling to the bilateral feet, bilateral shoulder pain and stiffness and bilateral elbow/forearm/wrist/hand pain and finger numbness. Physical examination showed cervical/thoracic/lumbosacral tenderness, bilateral shoulder tenderness and bilateral upper extremities tenderness-right greater than left. The treating physician is requesting and electromyography (EMG) of the bilateral upper and lower extremities, nerve conduction study (NCS) of the bilateral lower extremities, 8 sessions of chiropractic care of the cervical/thoracic/lumbar, bilateral forearms/wrists/elbows, Fexmid 7.5 mg #60 and Ultram 50 mg #30.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182, 260. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck & Upper Back.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-78.

Decision rationale: Per the MTUS ACOEM Guidelines, physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic exam are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic exam is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. EMG and nerve conduction velocities may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. In this case, the utilization review appropriately modified the request to allow for NCV given the distribution of symptoms, but with MRI, imaging there is no clear indication in the provided records for EMG at this time. Therefore, the request for EMG is not considered medically necessary at this time.

EMG bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Procedure Summary.

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

Decision rationale: Per the MTUS ACOEM Guidelines, physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic exam are sufficient evidence to warrant imaging studies if symptoms persist. Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. When the neurologic exam is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. In this case, there is no evidence of peripher neuropathy symptoms requiring clarification with EMG/NCV. Without clear provided indication of neurologic dysfunction that is evidential of need for electrodiagnostics, per the guidelines, the request for EMG/NCV is not considered medically necessary.

NCS bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Procedure Summary.

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

Decision rationale: Per the MTUS ACOEM Guidelines, physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic exam are sufficient evidence to warrant imaging studies if symptoms persist. Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. When the neurologic exam is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. In this case, there is no evidence of peripheral neuropathy symptoms requiring clarification with EMG/NCV. Without clear provided indication of neurologic dysfunction that is evidential of need for electrodiagnostics, per the guidelines, the request for EMG/NCV is not considered medically necessary.

8 sessions of chiropractic, cervical thoracic lumbar bilateral forearms/wrists/elbows:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines manual therapy and manipulation Page(s): 58-59.

Decision rationale: The MTUS Chronic Pain Management Guidelines (pg 58-59) indicate that manual therapy and manipulation are recommended as options in low back pain. With respect to therapeutic care, the MTUS recommends a trial of 6 visits over 2 weeks, with evidence of objective functional improvement allowing for up to 18 visits over 6-8 weeks. If the case is considered a recurrence/flare-up, the guidelines similarly indicate a need to evaluate treatment success. In either case, whether considered acute or recurrent, and in light of the patient's multiple complaints, the patient needs to be evaluated for functional improvement prior to the completion of 8 visits in order to meet the standards outlined in the guidelines. Overall, it is quite possible the patient may benefit from conservative treatment with manual therapy at this time. However, early re-evaluation for efficacy of treatment/functional improvement is critical. The guidelines indicate a time to produce effect of 4-6 treatments, which provides a reasonable timeline by which to reassess the patient and ensure that education, counseling, and evaluation for functional improvement occur. In this case, the request for a total of 8 visits to chiropractics without a definitive plan to assess for added clinical benefit prior to completion of the entire course of therapy is not considered medically necessary.

Fexmid 7.5mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants Page(s): 63.

Decision rationale: The MTUS recommends non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. However, in most cases, they seem no more effective than NSAIDs for treatment. There is also no additional benefit shown in combination with NSAIDs. With no clear evidence of spasm and a request for continued and chronic treatment, close follow up for functional improvement, etc., the quantity of medications currently requested cannot be considered medically necessary and appropriate.

Ultram 50mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 74-96.

Decision rationale: Chronic use of opioids is addressed thoroughly by the MTUS chronic pain guidelines and given the long history of pain in this patient since the initial date of injury, consideration of the MTUS Criteria for Use of Opioids in chronic pain is appropriate. Documentation of pain and functional improvement are critical components, along with documentation of adverse effects. While the MTUS does not specifically detail a set visit frequency for re-evaluation, recommended duration between visits is 1 to 6 months. In this case, the patient clearly warrants close monitoring and treatment, to include close follow up regarding improvement in pain/function; consideration of additional expertise in pain management should be considered if there is no evidence of improvement in the long term. More detailed consideration of long-term treatment goals for pain (specifically aimed at decreased need for opioids), and further elaboration on dosing expectations in this case would be valuable. Consideration of other pain treatment modalities and adjuvants is also recommended. Given the lack of clear evidence to support functional improvement on the medication, no plan for urine tox screening and risk assessment, and the chronic risk of continued treatment, the request for Ultram is not considered medically necessary.