

Case Number:	CM15-0143789		
Date Assigned:	08/04/2015	Date of Injury:	04/04/2015
Decision Date:	09/22/2015	UR Denial Date:	06/19/2015
Priority:	Standard	Application Received:	07/24/2015

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: California, Hawaii
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 36 year old female, who sustained an industrial injury on 4-04-2015, as the result of a motor vehicle accident, while working as a Registered Nurse. She developed pain in her back, stomach, and chest. The injured worker was initially diagnosed as having thoracic and lumbar sprains. Current diagnoses included disc herniation of the lumbar spine, thoracic strain with disc protrusion, cervical strain, upper extremity complaints-possible double crush syndrome, ulnar nerve compression, and constipation. Treatment to date has included diagnostics, medications, "limited" therapy (unspecified), and modified duties. Currently (6-04-2015), the injured worker complains of pain in her neck, back, thoracic spine, and lumbar spine. She had numbness of the hands and numbness of three fingers of the left hand. She had pain radiating to the right leg, pain in her knee, and pain in her shoulder. She reported constipation, anxiety, difficulty sleeping, and depression. Current medication regimen was not noted. The treatment plan included electromyogram and nerve conduction studies of the upper extremities, unspecified therapy and unspecified acupuncture, and an electrical heating pad. Her work status was not documented.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electromyography/Nerve Conduction Velocity of Upper Extremities: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 177-178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 8 Neck and Upper Back Complaints Page(s): 178, 260-262.

Decision rationale: The patient presents with pain affecting the low back with radiation down the bilateral lower extremities. The current request is for EMG of the right lower extremity. The treating physician report dated 6/30/15 (25B) states, "He recommends EMG/nerve conduction studies of the bilateral lower extremities to objectively evaluate the status of neuropathic pain and the affected levels." The report goes on to state, "He continues to report having significant low back pain with radiation into the lower extremities." The report further states, "Straight leg raise is positive on left and right." ACOEM page 303 states, "Electromyography (EMG) including H-reflex test may be useful to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks." Repeat studies are not addressed. The ODG guidelines state, "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." In this case, the patient has been diagnosed with radiculopathy and has positive examination findings. The physician has requested the EMG to help aid in the diagnosis and there is no documentation of a prior EMG scan performed. The current request is medically necessary.

Therapy (Unspecified): Upheld

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

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

Decision rationale: The patient presents with pain affecting the neck, thoracic spine and lumbar spine. The current request is for Therapy (unspecified). A report dated 6/4/15 (27B) states, "I am recommending therapy and acupuncture treatment." The report goes on to state, "She received limited therapy." MTUS supports physical medicine (physical therapy and occupational therapy) 8-10 sessions for myalgia and neuritis type conditions. The MTUS guidelines only provide a total of 8-10 sessions and the patient is expected to then continue on with a home exercise program. The medical reports provided show the patient has received prior physical therapy although the quantity of sessions received is unknown. The patient's status is not post-surgical. In this case, the current request does not specify a quantity of sessions to be received by the patient and therefore it is uncertain if it exceeds the recommendation of 8-10 visits as outlined by the MTUS guidelines on page 99. Furthermore, the MTUS guidelines do not support an open ended request. The current request is not medical necessary.

Acupuncture, unspecified: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Colorado DWC Guidelines, Acupuncture.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The patient presents with pain affecting the neck, thoracic spine and lumbar spine. The current request is for Acupuncture, unspecified. A report dated 6/4/15 (27B) states, "I am recommending therapy and acupuncture treatment." Review of the Acupuncture Medical Treatment Guidelines (AMTG) supports acupuncture for 3-6 treatments and treatments may be extended if functional improvement is documented. The guidelines go on to state "Frequency: 1 to 3 times per week, Optimum duration: 1 to 2 month." The medical reports provided do not show the patient has received acupuncture treatments previously. In this case, the current request does not specify a location for treatment or a quantity of treatments to be received and therefore it does not satisfy the AMTG guidelines as it only supports treatment beyond 3-6 visits if functional improvement is documented. Furthermore, the guidelines do not support an open ended request. The current request is not medical necessary.

Electrical Heating Pad: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low back chapter, Heat therapy.

Decision rationale: The patient presents with pain affecting the neck, thoracic spine and lumbar spine. The current request is for Electrical Heating Pad. The treating physician report dated 6/4/15 (27B) states, "I am recommending an electrical heating pad." The MTUS guidelines do not address the current request. The ODG guidelines state the following regarding heat therapy: "Recommended as an option. A number of studies show continuous low-level heat wrap therapy to be effective for treating low back pain." There is moderate evidence that heat wrap therapy provides a small short-term reduction in pain and disability in acute and sub-acute low-back pain, and that the addition of exercise further reduces pain and improves function. Heat therapy has been found to be helpful for pain reduction and return to normal function. In this case, the patient presents with pain affecting the low back and the treating physician is requesting authorization for a heat pad in order to improve the patient's function and provide her with partial relief of her symptoms. The current request satisfies the ODG guidelines as outlined in the "Low Back" chapter. The current request is medically necessary.