MAXIMUS Federal Services

Case Number:	CM15-0191894		
Date Assigned:	10/05/2015	Date of Injury:	02/21/2014
Decision Date:	12/09/2015	UR Denial Date:	09/11/2015
Priority:	Standard	Application Received:	09/29/2015

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, California
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 is a 49-year-old male, with a reported date of injury of 02-21-2014. The diagnoses include lumbar facet arthropathy, lumbar myofascial strain, low back pain, cervical facet arthropathy, cervical myofascial strain, and right ulnar neuropathy. Treatments and evaluation to date have included Cymbalta, Lorazepam, Omeprazole, Tramadol, Tylenol, Hydrocodone (itching), muscle relaxant (minimal relief), psychological treatment, and physical therapy. The diagnostic studies to date have included an MRI of the lumbar spine on 04/17/2014 which showed disc desiccation at L1-2 down to L5-S1 with associated loss of disc height at L4-5 and L5-S1, degenerative changes at the superior end plate of S1 and inferior end plate of L2, L4, and L5, disc herniation at L2-3, L3-4, L4-5, and L5-S1 with stenosis of the spinal canal and left lateral recess, and bilateral neural foramen and bilateral lateral recess at L4-5; an MRI of the left shoulder at 04-18-2014 which showed minimal subacromial and subscapularis bursitis; an MRI of the right shoulder on 04-18-2014 which showed minimal subacromial and subscapularis bursitis and osteoarthropathy of the acromioclavicular joint; and an MRI of the thoracic spine on 04-18-2014 which showed fatty infiltration of the paraspinal area at the mid thoracic levels. The progress report dated 09-01-2015 indicates that the injured worker complained of neck and low back pain. It was noted that the injured worker was currently not working, and he reported that he was gradually getting worse. Since his last visit, the injured worker's stated that his symptoms remained unchanged. The injured worker rated his neck pain 3-7 out of 10, and his low back pain 5-6 out of 10. On 07-20-2015, it was noted that the injured worker rated his neck pain 3 out of 10 and his low back pain 3 out of 10. It was noted that an x-ray of the lumbar spine showed

anterior spondylosis and disc space narrowing at L5-S1; and an x-ray of the cervical spine showed anterior spondylosis, straightening of the lordotic curve, loss of height at C6, and disc space narrowing at C5-6 and C6-7. The physical examination showed negative bilateral straight leg raise test; intact sensation to light touch and pinprick to the C2-S2 dermatomes; a normal gait pattern; tenderness to palpation of the L3-S1 bilateral dermatomes and right medial elbow epicondyle; decreased bilateral lumbar extension; and positive bilateral lumbar facet loading. The request for authorization was dated 07-20-2015. The treating physician requested a medial branch block at the bilateral L4-5 and L5-S1; 8 physical therapy sessions to the cervical spine; 8 physical therapy sessions to the lumbar spine; EMG and NCS (electromyography and nerve conduction study) of the right upper extremity due to ulnar neuropathy; and 16 acupuncture sessions due to cervical myofascial strain. On 09-11-2015, Utilization Review (UR) modified the request for a medial branch block at the bilateral L4-5 and L5-S1; 8 physical therapy sessions to the cervical spine; 8 physical therapy sessions to the lumbar spine; EMG and NCS (electromyography and nerve conduction study) of the right upper extremity; and modified the request for and 16 acupuncture sessions to a trial of 3 acupuncture sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Medial branch block L4-L5 and L5-S1 bilateral: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Examination, Diagnostic Criteria, Initial Care, Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Facet joint medial branch blocks.

Decision rationale: According the above referenced guideline, "Invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. Although epidural steroid injections may afford short-term improvement in leg pain and sensory deficits in patients with nerve root compression due to a herniated nucleus pulposus, this treatment offers no significant long-term functional benefit, nor does it reduce the need for surgery. Despite the fact that proof is still lacking, many pain physicians believe that diagnostic and/or therapeutic injections may have benefit in patients presenting in the transitional phase between acute and chronic pain." ODG guidelines state that medial branch blocks "Not recommended except as a diagnostic tool. Minimal evidence for treatment." There is no discussion in the records this block is requested for diagnosis. There is no discussion of surgery. In addition, the request does not discuss what is being injected. It is unclear if a steroid or an anesthetic is being used. Without the documentation or support of the guidelines, the request is determined not medically necessary.

Physical therapy x 8 to cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: CA MTUS chronic pain guidelines for manual therapy and manipulation are used in support of this decision. This request is for ongoing physical therapy as the IW has completed 6 sessions. Documentation does not include a measure of functional improvement resulting from these treatments. Other conservative treatments with the exception of medications are not included in the chart materials. There is no documentation to assess activities of daily living. The maximum recommended quantity of Physical Medicine visits is 10, with progression to home exercise. Guidelines do not recommend maintenance care. Additionally, 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 8 physical therapy sessions would exceed the recommendations and therefore is determined not medically necessary.

Physical therapy x 8 to lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: CA MTUS chronic pain guidelines for manual therapy and manipulation are used in support of this decision. This request is for ongoing physical therapy as the IW has completed 6 sessions. Documentation does not include a measure of functional improvement resulting from these treatments. Other conservative treatments with the exception of medications are not included in the chart materials. There is no documentation to assess activities of daily living. The maximum recommended quantity of Physical Medicine visits is 10, with progression to home exercise. Guidelines do not recommend maintenance care. Additionally, 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 8 physical therapy sessions would exceed the recommendations and therefore is determined not medically necessary.

Acupuncture x 16 visits: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment 2007.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment 2007.

Decision rationale: The prescription for acupuncture is evaluated in light of the MTUS recommendations for acupuncture. It is not clear that any acupuncture has been performed to date. Assuming the current prescription is for an initial course, the prescription is for 12 visits, which exceeds the quantity recommended in the MTUS of 3 to 6 visits. As discussed in the

MTUS, chronic pain section, the goal of all treatment for chronic pain is functional improvement, in part because chronic pain cannot be cured. An initial course of acupuncture is not medically necessary based on a prescription which exceeds the quantity recommended in the MTUS.

EMG/NCS of right upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Physical Examination, Diagnostic Criteria, Special Studies.

Decision rationale: There are no reports from the prescribing physician, which adequately describe neurologic findings leading to medical necessity for 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. Non-specific, non-dermatomal extremity symptoms are not sufficient alone to justify electrodiagnostic testing. 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. For example, a diagnosis of radiculopathy should be supported by the signs and symptoms listed in the MTUS cited above. Based on the recent clinical information, there are no neurologic abnormalities and no specific neurologic symptoms. Without the support of the documentation or adherence to the guidelines, the request is determined not medically necessary.