

Case Number:	CM15-0023108		
Date Assigned:	02/12/2015	Date of Injury:	09/30/2008
Decision Date:	04/09/2015	UR Denial Date:	02/03/2015
Priority:	Standard	Application Received:	02/06/2015

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

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 (IW) is a 55-year-old male who sustained an industrial injury on 09/30/2008. He has reported neck pain, back pain, loss of balance, chest pain, stiff joints, and poor sleep. Diagnoses include unspecified neuritis, neuralgia, and radiculitis carpal tunnel syndrome, lesion of ulnar nerve, and tarsal tunnel syndrome. Treatments to date include a failed back surgery, caudal epidural steroid injections, and spinal cord stimulator. The IW also takes Norco, Ibuprofen, and uses Lidoderm patches. A progress note from the treating provider dated 11/20/2014-indicates the worker has chronic neck pain post cervical epidural steroid injections and chronic low back pain with radicular symptoms. He has stiffness in the joints, with decreased range of motion in lumbar forward flexion and extension with mild facet loading positive bilaterally. He has normal reflexes, and slightly decreased sensation to light touch in both legs below knee level. Plan of care was to continue the Norco 10/325mg three times daily, Lidoderm patches, and as needed ibuprofen, and to request a lumbar epidural steroid injection with transforaminal approach based on MRI findings. On 02/03/2015 Utilization Review non-certified a request for EMG/NCV Upper Extremity, The MTUS, ACOEM Guidelines were cited, On 02/03/2015 Utilization Review non-certified a request for Home Based trial neurostimulator. The MTUS, ACOEM Guidelines were cited. On 02/03/2015 Utilization Review non-certified a request for MRI right knee. The MTUS, ACOEM Guidelines were cited. On 02/03/2015 Utilization Review non-certified a request for TENS (1) month, The MTUS, ACOEM Guidelines, (or ODG) were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI right knee: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343. Decision based on Non-MTUS Citation Official Disability Guidelines-TWC Knee and Leg procedure.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Knee and Leg chapter, Magnetic resonance imaging.

Decision rationale: The patient presents with chronic unrated neck and lower back pain. The patient's date of injury is 09/30/08. Patient is status post multiple cervical ESI's at levels and dates unspecified. The request is for MRI OF THE RIGHT KNEE. The RFA was not provided. Physical examination dated 11/20/14 reveals mild facet loading to the lumbar spine and decreased lumbar range of motion. Neurological examination reveals mildly positive straight leg raise test bilaterally, minimally decreased sensation to light touch bilaterally below knee level. No other examination findings are included. The patient is currently prescribed Norco, Lidoderm patches, and Ibuprofen. Diagnostic imaging included MRI of the lumbar spine dated 01/06/09, significant findings include: "L3-L4 3mm retrolisthesis of L3 on L4, L4-L5 there is disc dehydration 3mm disc bulge seen with. Left posterior annular tear resulting in mild facet arthropathy and mild encroachment on the right neuroforamen." Patient's current work status was not provided. ODG Guidelines, Knee and Leg chapter, Magnetic resonance imaging states: "Indications for imaging MRI: Acute trauma to the knee, including significant trauma, or if suspect posterior knee dislocation or ligament or cartilage disruption. Nontraumatic knee pain, child or adolescent: nonpatellofemoral symptoms. Initial anteroposterior and lateral radiographs nondiagnostic next study if clinically indicated, if additional study is needed. Nontraumatic knee pain, child or adult. Patellofemoral symptoms. Initial anteroposterior, lateral, and axial radiographs nondiagnostic . If additional imaging is necessary and if internal derangement is suspected. Nontraumatic knee pain, adult. Nontrauma, nontumor, nonlocalized pain, Initial anteroposterior and lateral radiographs nondiagnostic. Nontraumatic knee pain, adult nontrauma, nontumor, nonlocalized pain. Initial anteroposterior and lateral radiographs demonstrate evidence of internal derangement."In regards to the request for MRI imaging to be performed on the knee, treater has not provided any subjective complaints or pertinent examination findings to support such imaging. There is no evidence this patient has had an MRI of the knee to date, but without a clearer picture of this patient's clinical presentation such imaging cannot be substantiated. There are no red flags or exam findings requiring an MRI. The request IS NOT medically necessary.

EMG/NCV Upper Extremity: Overturned

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-TWC: Neck & Back procedure summary last updated 11/18/2014,

Electrodiagnostic studies. The American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) recommends: ODG; Neck & Upper Back.

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

Decision rationale: The patient presents with chronic unrated neck and lower back pain. The patient's date of injury is 09/30/08. Patient is status post multiple cervical ESI's at levels and dates unspecified. The request is for EMG/NCV UPPER EXTREMITY. The RFA was not provided. Physical examination dated 11/20/14 reveals mild facet loading to the lumbar spine and decreased lumbar range of motion. Neurological examination reveals mildly positive straight leg raise test bilaterally, minimally decreased sensation to light touch bilaterally below knee level. No other examination findings are included. The patient is currently prescribed Norco, Lidoderm patches, and Ibuprofen. Diagnostic imaging included MRI of the lumbar spine dated 01/06/09, significant findings include: "L3-L4 3mm retrolisthesis of L3 on L4, L4-L5 there is disc dehydration 3mm disc bulge seen with left posterior annular tear resulting in mild facet arthropathy and mild encroachment on the right neuroforamen." Patient's current work status was not provided. ACOEM Practice Guidelines, 2nd Edition 2004, Chapter 11, page 260-262 states: Appropriate electrodiagnostic studies EDS may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies NCS, or in more difficult cases, electromyography EMG may be helpful. NCS and EMG may confirm the diagnosis of CTS but may be normal in early or mild cases of CTS. If the EDS are negative, tests may be repeated later in the course of treatment if symptoms persist. In regards to the request for an EMG/NCV study to be performed on the upper extremities, the request appears reasonable. Progress note dated 08/07/14 indicates that this patient has decreased upper extremity sensation on the right side along the lower cervical dermatomal distributions. Records provided do not indicate that the patient has not had an NCV/EMG performed to date. Such diagnostics are supported by guidelines to differentiate between cervical radiculopathy and carpal tunnel syndrome. Therefore, this request IS medically necessary.

Home Based trial neurostimulator: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 340. Decision based on Non-MTUS Citation Official Disability Guidelines-TWC Knee and Leg procedure updated 10/27/2014, evidence citation for home-based trial neurostimulator.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulator NMES devices Page(s): 121.

Decision rationale: The patient presents with chronic unrated neck and lower back pain. The patient's date of injury is 09/30/08. Patient is status post multiple cervical ESI's at levels and dates unspecified. The request is for HOME BASED TRIAL NEUROSTIMULATOR. The RFA was not provided. Physical examination dated 11/20/14 reveals mild facet loading to the lumbar spine and decreased lumbar range of motion. Neurological examination reveals mildly positive straight leg raise test bilaterally, minimally decreased sensation to light touch bilaterally below

knee level. No other examination findings are included. The patient is currently prescribed Norco, Lidoderm patches, and Ibuprofen. Diagnostic imaging included MRI of the lumbar spine dated 01/06/09, significant findings include: "L3-L4 3mm retrolisthesis of L3 on L4, L4-L5 there is disc dehydration 3mm disc bulge seen with left posterior annular tear resulting in mild facet arthropathy and mild encroachment on the right neuroforamen." Patient's current work status was not provided. Per MTUS guidelines page 121, Nuromuscular electrical stimulator NMES devices is not recommended. NMES is used primarily as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. In regards to the request for a home based neurostimulator trial for this patient's chronic neck and lower back pain, the requested device is not supported by guidelines for chronic pain. While this patient presents with continuing pain unresolved by conservative measures and epidural steroid injections, MTUS does not consider neurostimulators appropriate for chronic pain conditions. Therefore, the request IS NOT medically necessary.

TENS (1) month: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114-116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS in chronic intractable pain Page(s): 116.

Decision rationale: The patient presents with chronic unrated neck and lower back pain. The patient's date of injury is 09/30/08. Patient is status post multiple cervical ESI's at levels and dates unspecified. The request is for TENS 1 MONTH. The RFA was not provided. Physical examination dated 11/20/14 reveals mild facet loading to the lumbar spine and decreased lumbar range of motion. Neurological examination reveals mildly positive straight leg raise test bilaterally, minimally decreased sensation to light touch bilaterally below knee level. No other examination findings are included. The patient is currently prescribed Norco, Lidoderm patches, and Ibuprofen. Diagnostic imaging included MRI of the lumbar spine dated 01/06/09, significant findings include: "L3-L4 3mm retrolisthesis of L3 on L4, L4-L5 there is disc dehydration 3mm disc bulge seen with left posterior annular tear resulting in mild facet arthropathy and mild encroachment on the right neuroforamen." Patient's current work status was not provided. According to MTUS Chronic Pain Management Guidelines the criteria for the use of TENS in chronic intractable pain page 116 "a one-month trial period of the TENS unit should be documented as an adjunct to other treatment modalities within a functional restoration approach with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function during this trial." In regards to what appears to be a one month trail for a TENS unit, the request appears reasonable. Progress reports provided do not indicate that this patient has tried a TENS unit to date. MTUS guidelines support a one month trial of TENS unit therapy as an adjunct to other treatment modalities and purchase of a unit with documented trial benefits. Therefore, the request IS medically necessary.