

Case Number:	CM15-0027149		
Date Assigned:	02/19/2015	Date of Injury:	01/29/2013
Decision Date:	05/01/2015	UR Denial Date:	01/30/2015
Priority:	Standard	Application Received:	02/12/2015

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

Certification(s)/Specialty: Anesthesiology

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 47 year old male, who sustained an industrial injury on 1/20/2013. The diagnoses have included thoracic spine sprain/strain, lumbar spine neuropathy and radiculopathy, right knee medial meniscus tear and right patellar ganglion cyst. Treatment to date has included acupuncture, chiropractic and medications. Currently, the IW complains of constant mild to moderate upper/mid back pain and stiffness rated as 5/10. There is lumbar spine pain rated as 7/10. Objective findings included lower back tenderness to palpation. Straight leg raise and Lasague caused pain bilaterally. There is decreased range of motion. On 1/30/2015, Utilization Review non-certified a request for physical therapy 1-2 times a week for 4 weeks lumbar, infrared therapy, acupuncture with stimulation 15 min and acupuncture with stimulation additional 15 min 1-2 times a week for 4 weeks lumbar, MD for medication/MD referral for med consult, magnetic resonance imaging (MRI) lumbar spine, EMG (electromyography)/NCV (nerve conduction studies) bilateral lower extremities, and mechanical traction therapy, massage therapy, ultrasound, diathermy, electrical stimulation, comp asst00 EMS and matrix - 1-2 times a week for 4 weeks lumbar noting that the clinical information submitted for review fails to meet the evidence based guidelines for the requested service. The MTUS and ACOEM Guidelines were cited. On 2/12/2015, the injured worker submitted an application for IMR for review of physical therapy 1-2 times a week for 4 weeks lumbar.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 1 to 2 times a week for 4 weeks, lumbar: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical therapy.

Decision rationale: According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Per ODG, patients should be formally assessed after a "6-visit trial" to see progress made by patient. Additional treatment would be assessed based on functional improvement and appropriate goals for additional treatment. According to the records, this patient has had prior PT visits since his injury in 01/2013. There is no documentation indicating that he had a defined functional improvement in his condition. There is no specific indication for the additional physical therapy sessions requested at this time. Medical necessity for the additional PT visits requested has not been established. The requested services are not medically necessary.

Infrared therapy, acupuncture with stimulation 15min and acupuncture with stimulation for an additional 15mins 1 to two times a week for 4 weeks, lumbar: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: According to the Acupuncture Medical Treatment Guidelines, 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 recovery. The treatment guidelines support acupuncture treatment to begin as an initial treatment of 3-6 sessions over no more than two weeks. If functional improvement is documented, as defined by the guidelines further treatment will be considered. In this case, there is documentation of previous acupuncture sessions however, there is no documentation of objective improvement with previous acupuncture treatments. In addition, given the associated requests for physical therapy and chiropractic therapy, there is no documentation of a rationale for providing concurrent physical treatments. Medical necessity for the requested acupuncture sessions has not been established. The requested service is not medically necessary.

M.d. for medication/M.D. referral or medical consult: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Page(s): Chapter 7.

Decision rationale: ACOEM Guidelines state that a medical consultation referral is supported if a diagnosis is uncertain or complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. In this case, the medical records are clear and uncomplicated for a diagnosis of degenerative joint disease with radiculopathy, and would not support additional management in the absence of regressive symptoms. Medical necessity for the requested service is not established. The requested consultation is not medically necessary.

MRI Lumbar spine: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304, Chronic Pain Treatment Guidelines MRI of the lumbar spine Page(s): 304.

Decision rationale: According to California MTUS Guidelines, MRI of the lumbar spine is recommended to evaluate for evidence of cauda equina, tumor, infection, or fracture when plain films are negative and neurologic abnormalities are present on physical exam. In this case, there is no indication for a repeat MRI of the lumbar spine. The documentation indicates that the claimant had a previous MRI of the lumbar spine which demonstrated multilevel degenerative changes. There are no subjective complaints of increased back pain, radiculopathy, bowel or bladder incontinence, and there are no new neurologic findings on physical exam. Therefore, there is no specific indication for a repeat MRI of the lumbar spine. Medical necessity for the requested MRI has not been established. The requested imaging is not medically necessary.

EMG/NCV BLE (Bilateral Lower Extremities): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Nerve Conduction Velocity Testing.

Decision rationale: According to the ODG, EMG (Electromyography) and nerve conduction studies (NCS) are an extension of the physical examination. EMGs and NCSs are generally accepted, well-established and widely used for aiding in the diagnosis of peripheral nerve and muscle problems. This can include neuropathies, entrapment neuropathies (e.g. CTS), radiculopathies, and muscle disorders. The California MTUS/ACOEM Guidelines state that

EMG and NCVs, including H-reflex tests, may help identify subtle, focal neurologic dysfunction in patients with neck or arm problems, or both, lasting more than 3 to 4 weeks. The ODG further states that NCVs (or NCSs) are recommended if the EMG is not clearly a radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes. EMG is recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if the radiculopathy is already clinically obvious. In this case, prior electro-diagnostic studies were obtained with evidence of bilateral S1 radiculopathy and possible peroneal neuropathy. There is no specific indication for repeat studies. Medical necessity for the requested service has not been established. The requested service is not medically necessary.

Mechanical traction therapy, massage therapy, ultrasound, diathermy, electrical stimulation, comp asst EMS and matrix-1 to 2 times a week for 4 weeks, Lumbar: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical MedicineManual Medicine Page(s): 98, 58-60.

Decision rationale: According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Per ODG, patients should be formally assessed after a "6-visit trial" to see progress made by patient. Additional treatment would be assessed based on functional improvement and appropriate goals for additional treatment. According to the records, this patient has had prior PT visits since his injury in 01/2013. There is no documentation indicating that he had a defined functional improvement in his condition. There is no specific indication for the additional physical therapy sessions requested at this time. According to MTUS, Manual Therapy or Chiropractic therapy, is recommended for chronic pain if it is caused by musculoskeletal conditions. The intended goal or effect is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. For the treatment of low back pain, a trial of 6 visits is recommended over 2 weeks, with evidence of objective improvement, with a total of up to 18 visits over 6-8 weeks. If manipulation has not resulted in functional improvement in the first one or two weeks, it should be stopped and the patient reevaluated. In this case, the patient has been receiving chiropractic therapy since April 2014 with evidence that applied passive modalities have been applied to the patient's lower back. There was no documentation of objective functional improvement from prior chiropractic treatments. Medical necessity for the requested services have not been established. The requested services are not medically necessary.