

Case Number:	CM15-0045521		
Date Assigned:	04/03/2015	Date of Injury:	12/09/2013
Decision Date:	05/20/2015	UR Denial Date:	02/16/2015
Priority:	Standard	Application Received:	03/10/2015

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 is 54-year-old female who reported injury on 12/09/2013. The injured worker was noted to undergo an MRI of the lumbar spine on 01/31/2014 and an electrodiagnostic studies on 12/20/2013. The most recent documentation submitted for review was dated 11/21/2014. The mechanism of injury was not provided. The injured worker had complaints of low back pain radiating down the left lower extremity. The injured worker indicated she had a procedure scheduled for a carpal tunnel release. The injured worker was scheduled for carpal tunnel surgery. The physical examination of the lumbar spine revealed tenderness to palpation of the lumbar spine. Sensation was within normal limits. Motor examination revealed slight decreased strength in left lower extremity. The straight leg raise with the injured worker in the seated position was positive for radicular pain at 45 degrees. The diagnostic studies that were reviewed included an EMG/NCV of 09/20/2013 which revealed moderate bilateral carpal tunnel syndrome characterized by focal demyelination and no denervation. The left side was worse than the right. There was no evidence of upper extremity radiculopathy or plexopathy. The injured worker was noted to undergo an MRI of the lumbar spine dated 01/31/2014 which revealed a questionable minimal grade 1 spondyliosthesis at L4-5. There was no spondylosis seen. This was in accommodation of mild to moderate narrowing of the L4-5 apophyseal joint bilateral resulting in mild spinal stenosis and bilateral foraminal narrowing at this level. There was mild to moderate narrowing involving the remainder of the lumbar facet joints. The treatment plan included the injured worker had a procedure pending authorization and scheduling. The injured worker had trialed physical therapy with some benefit

however experienced pain. The injured worker had trialed acupuncture with limited benefit. The request was made for the documentation indicating a transforaminal epidural steroid injection was authorized. It was noted it should be scheduled. The prescriptions included cyclobenzaprine 7.5 mg, naproxen sodium, and nizatidine 150 mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 1-2 x per week QTY 8: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines Page(s): 99.

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

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend physical medicine treatment for up to 10 visits for myalgia and myositis. The clinical documentation submitted for review indicated the injured worker had previously undergone physical medicine treatment. There was a lack of documentation of objective functional benefit and objective decrease in pain. The quantity of sessions previously attended were not provided. The remaining functional deficits were not provided. The request as submitted failed to indicate the body part to be treated. Given the above, the request for physical therapy 1-2 times per week quantity 8 is not medically necessary.

Mechanical Traction 1-2 x per week QTY 8: 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.

Decision rationale: The Official Disability Guidelines indicate that traction is not recommended using a power traction device, but a home based injured worker controlled unit, gravity traction unit, may be used as a noninvasive conservative option if it is used adjunct to a program of evidence based conservative care to achieve functional restoration. The clinical documentation submitted for review failed to provide documentation of the rationale for the request. There was no physician documentation requesting the traction. The request as submitted failed to indicate the body part to be treated. There was a lack of documentation of exceptional factors to warrant non-adherence to guideline recommendation. Given the above, the request for mechanical traction 1-2 x per week qty 8 is not medically necessary.

Diathermy 1-2 x per week QTY 8: 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) Low Back Chapter, diathermy.

Decision rationale: The Official Disability Guidelines indicate that diathermy is not recommended. There was a lack of documentation of exceptional factors to warrant non-adherence to guideline recommendations. The request as submitted failed to indicate the body part to be treated. Given the above the request for diathermy 1-2 x per week qty 8 is not medically necessary.

Electrical Stimulation 1-2 x per week QTY 8: 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 Transcutaneous electrotherapy Page(s): 114.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend electrotherapy that can be used in a treatment of pain. However, the request as submitted failed to provide documentation of the specific electrical stimulation being requested, so that specific guidelines could be applied. The request as submitted failed to indicate the body part to be treated. Given the above, the request for electrical stimulation 1-2 x per week qty 8 is not medically necessary.

Ultrasound 1-2 x per week QTY 8: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ultrasound, therapeutic Page(s): 123.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines indicate that therapeutic ultrasound is not recommended. There was a lack of documentation of exceptional factors. The request as submitted failed to indicate the body part to be treated. Given the above the request for ultrasound 1-2 x per week qty 8 is not medically necessary.

Myofascial Release 1-2 x per week QTY 8: 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 Massage therapy Page(s): 60.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend massage therapy as an adjunct to other recommended treatment and it should be limited to 4-6 visits however benefits were registered only during treatment. The request for 8 visits would be excessive. The body part to be treated was not provided per the submitted request. Given the above the request for myofascial release 1-2 x per week qty 8 is not medically necessary.

Acupuncture 1-2 x per week QTY 8: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines state that acupuncture is used as an option when pain medication is reduced or not tolerated and it is recommended as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. The time to produce functional improvement is 3 - 6 treatments and Acupuncture treatments may be extended if functional improvement is documented including either a clinically significant improvement in activities of daily living or a reduction in work restrictions. The clinical documentation submitted for review failed to provide documentation the acupuncture would be utilized as an adjunct to physical rehabilitation. There was a lack of documentation indicating pain medication was reduced or not tolerated. The request for 8 sessions would be excessive. The documentation indicated the injured worker had previously utilized acupuncture. However there was a lack of documentation of the quantity of sessions and that a clinically significant improvement in activities of daily living was a result from the treatment. The request as submitted failed to indicate the body part to be treated. Given the above, the request for acupuncture 1-2 x per week qty 8 is not medically necessary.

Infrared 1-2 x per week QTY 8: 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) Low Back Chapter, Infrared therapy (IR).

Decision rationale: The Official Disability Guidelines indicate that infrared therapy is not recommended over other heat therapies. There was a lack of documentation of exceptional factors to warrant non-adherence to guidelines recommendations. The request as submitted failed to indicate the body part to be treated. Given the above the request for infrared 1-2 x per week qty 8 is not medically necessary.

MRI Lumbar Spine QTY 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, MRI.

Decision rationale: The Official Disability Guidelines indicate a repeat MRI is recommended when there is documentation of a significant change in objective findings upon physical examination or a significant change of symptomatology. The clinical documentation submitted for review indicated the injured worker had undergone an MRI on 01/31/2014. There was a lack of documentation of a significant change in symptoms or objective findings. Given the above, the request for MRI lumbar spine quantity 1 is not medically necessary. There was no rationale submitted for the requested service.

EMG/NCV bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Nerve conduction studies (NCS).

Decision rationale: The American College of Occupational and Environmental Medicine states that 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. They do not address NCS of the lower extremities. As such, secondary guidelines were sought. The Official Disability Guidelines do not recommend NCS as there is minimal justification for performing nerve conduction studies when an injured worker is presumed to have symptoms on the basis of radiculopathy. There is no documentation of peripheral neuropathy condition that exists in the bilateral lower extremities. There is no documentation specifically indicating the necessity for both an EMG and NCV. The clinical documentation submitted for review indicated the injured worker's sensory examination was within normal limits and motor examination revealed a slight decrease in the strength of left lower extremity. However there was a lack of documentation of significant findings to support the necessity for both an EMG and NCV. There was a lack of documentation of exceptional factors to warrant non-adherence to guideline recommendation. There was a lack of documentation of a failure of conservative care. The physician documentation requesting the treatment was not provided. There was no Request for Authorization submitted for review. The date of service being requested was not provided. Given the above to request for EMG/NCV bilateral lower extremities is not medically necessary.

Interferential Unit 5 month rental QTY 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118.

Decision rationale: The California Medical Treatment & Utilization Schedule guidelines do not recommend interferential current stimulation (ICS) as an isolated intervention and should be used with recommended treatments including work, and exercise. The clinical documentation submitted for review failed to support the necessity for physical medicine. There was a lack of documentation indicating a necessity for a 5 month rental. The request as submitted failed to indicate the body part to be treated with the interferential unit. There was a lack of documentation indicating exceptional factors. Given the above the request for interferential unit 5 month rental qty 1 is not medically necessary.