

Case Number:	CM15-0059849		
Date Assigned:	04/06/2015	Date of Injury:	10/23/2014
Decision Date:	06/01/2015	UR Denial Date:	03/23/2015
Priority:	Standard	Application Received:	03/30/2015

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: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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 female who sustained an industrial injury on 10/23/2014. Diagnoses include chronic cervical strain rule out disc herniation, chronic lumbar strain rule out disc herniation, left cubital tunnel syndrome, and bilateral carpal tunnel syndrome. Treatment to date has included diagnostic studies, medications, occupational therapy, elbow splint, carpal tunnel braces, and home exercise program. A physician progress note dated 02/25/2015 documents the injured worker has pain in her neck with radiation of pain into upper extremities, back, left elbow and wrists. Neck pain is rated 7/10, bilateral shoulder pain which radiates to both arms is rated a 10/10, and bilateral hands and wrist pain is rated a 10/10. The treatment plan is for Magnetic Resonance Imaging of the cervical and lumbar spine and below requested treatments. Treatment requested is for EMG/NCV study of the bilateral lower extremity, Ergonomic work station, physical therapy for the cervical spine and lumbar spine, twice weekly for six weeks, Ultram 50 mg, ninety count with no refills, Kera-tek analgesic gel, and Urine toxicology screen.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV study of the bilateral lower extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): table 8-7, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state electromyography, 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. In this case, the injured worker does have objective evidence of possible lumbar radiculopathy. However, the injured worker is also pending authorization for an MRI of the lumbar spine as well as a course of physical therapy. Given the above, the request for an electro diagnostic study is not medically necessary at this time.

Physical therapy for the cervical spine and lumbar spine, twice weekly for six weeks:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines.

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

Decision rationale: The California MTUS Guidelines recommend active therapy 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. Treatment for unspecified neuritis, neuralgia and radiculitis includes 8 to 10 visits over 4 weeks. The request for 12 sessions of physical therapy would exceed guideline recommendations. As such, the request is not medically necessary.

Ergonomic workstation: 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) Knee & Leg Chapter, Durable Medical Equipment.

Decision rationale: The Official Disability Guidelines recommend durable medical equipment if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment. In this case, the injured worker has continued to work with restrictions and has ongoing complaints of chronic pain. However, it is unclear how the requested item will

specifically address the current condition or improve function. As such, the medical necessity has not been established. Therefore, the request is not medically necessary.

Urine toxicology screen: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 43, 77 and 89. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Urine Drug Testing.

Decision rationale: California MTUS Guidelines state drug testing is recommended as an option, using a urine drug screen to assess for the use or presence of illegal drugs. The Official Disability Guidelines state the frequency of urine drug testing should be based on documented evidence of risk stratification. Patients at low risk of addiction or aberrant behaviors should be tested within 6 months of initiation of therapy and on a yearly basis thereafter. As per the clinical notes submitted, there is no mention of non-compliance or misuse of medication. There is no indication that this injured worker falls under a high-risk category that would require frequent monitoring. Therefore, the current request is not medically necessary.

Ultram 50 mg, #90 with no refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: The California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects should occur. In this case, there is no documentation of a failure to respond to non-opioid analgesics. There is also no frequency listed in the request. As such, the request is not medically necessary.

Kera-tek analgesic gel: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They

are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication that this injured worker has tried and failed oral medication. The medical necessity for the requested topical analgesic has not been established. There is also no frequency or quantity listed. Given the above, the request is not medically necessary.