

Case Number:	CM15-0064243		
Date Assigned:	04/28/2015	Date of Injury:	04/29/2014
Decision Date:	07/29/2015	UR Denial Date:	03/04/2015
Priority:	Standard	Application Received:	04/03/2015

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: Internal 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 44 year old male, who sustained an industrial injury on 04/29/2014. He has reported subsequent neck, back, right shoulder, knee, ankle and foot pain and was diagnosed with cervical, lumbar and right shoulder myospasm, lumbar disc displacement, lumbar disc protrusion, lumbar facet arthropathy, right shoulder and right ankle sprain/strain. Treatment to date has included oral and topical pain medication, aquatherapy, application of heat and ice and bracing. In a progress note dated 02/09/2015, the injured worker complained of neck, low back, right shoulder, knee, ankle and foot pain. Objective findings were notable for decreased range of motion of the cervical and lumbar spine, right shoulder, right knee, ankle and foot. A request for authorization of 6 sessions of chiropractic therapy, orthopedic surgery consult for the lumbar spine, NCV/EMG of the lumbar spine, cold/heat therapy unit rental, lumbar brace and TENS/EMS unit was submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic therapy 1 time a week for 6 weeks (6 sessions): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines manual therapy & manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58.

Decision rationale: Per MTUS guidelines it is recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine 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. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. The Medical Records do not indicate any functional benefit, this injured worker had from prior Chiropractic visits. The request for Chiropractic therapy is not medically necessary and appropriate.

Orthopedic surgeon consultation for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 92. Decision based on Non-MTUS Citation ACOEM 2004: OMPG, Independent Medical Examinations and Consultations, Chapter 7ACOEM Guidelines, page 305.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management, Chapter 12 Low Back Complaints Page(s): 92, 305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Office visits.

Decision rationale: As per MTUS/ACOEM Referral may be appropriate if the practitioner is uncomfortable with treating a particular cause of delayed recovery (such as substance abuse), or has difficulty obtaining information or agreement to a treatment plan. Depending on the issue involved, it often is helpful to "position" a behavioral health evaluation as a return-to-work evaluation. The goal of such an evaluation is, in fact, functional recovery and return to work. Collaboration with the employer and insurer is necessary to design an action plan to address multiple issues, which may include arranging for an external case manager. The physician can function in this role, but it may require some discussion to insure compensation for assuming this added responsibility. As per MTUS/ACOEM, Chapter 12, Low Back Complaints Surgical Considerations: Within the first three months after onset of acute low back symptoms, surgery is considered only when serious spinal pathology or nerve root dysfunction not responsive to conservative therapy (and obviously due to a herniated disk) is detected. Disk herniation, characterized by protrusion of the central nucleus pulposus through a defect in the outer annulus fibrosis, may impinge on a nerve root, causing irritation, back and leg symptoms, and nerve root dysfunction. The presence of a herniated disk on an imaging study, however, does not necessarily imply nerve root dysfunction. Studies of asymptomatic adults commonly demonstrate intervertebral disk herniations that apparently do not cause symptoms. Some studies show spontaneous disk resorption without surgery, while others suggest that pain may be due to irritation of the dorsal root ganglion by inflammogens (metalloproteinases, nitric oxide, interleukin-6, prostaglandin E2) released from a damaged disk in the absence of anatomical

evidence of direct contact between neural elements and disk material. Therefore, referral for surgical consultation is indicated for patients who have: Severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise. Activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms. Clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from Official Disability Guidelines (ODG) recommend office visits as determined to be medically necessary. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment. Physician may refer to other specialists if diagnosis is complex or extremely complex. Consultation is used to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability. The treating provider does not explain why referral is needed. Medical records are not clear about any change in injured worker's chronic symptoms. Given the lack of documentation and considering the given guidelines, the request is not medically necessary

NCV/EMG of the lumbar spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM guidelines, page 303, 309, Official Disability Guidelines, Low Back Chapter, Nerve Conduction Studies (NCS), EMGs (electromyography).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Electrodiagnostic testing (EMG/NCS).

Decision rationale: The California MTUS/ACOEM Guidelines state, "Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks." The ODG regarding nerve conduction studies (NCS) states, "Not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy... EMGs (electromyography) are 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 radiculopathy is already clinically obvious." The records of injured worker mention neck, back, right shoulder, knee, ankle and foot pain. The objective findings on examination did not include evidence of neurologic dysfunction such as sensory, reflex, or motor system change. The injured worker is not presented as having radiculopathy and there were no symptoms or findings that define evidence of a peripheral neuropathy. There is insufficient information provided by the treating health care provider to establish the medical necessity or rationale for the requested electrodiagnostic studies. The request for an EMG/NCV of the lumbar spine is not medically necessary and appropriate.

Cold/Heat therapy unit rental: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Cold/heat packs.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter Cold/heat packs.

Decision rationale: ODG recommends Ice massage compared to control had a statistically beneficial effect on ROM, function and knee strength. Cold packs decreased swelling. Hot packs had no beneficial effect on edema compared with placebo or cold application. Ice packs did not affect pain significantly compared to control in patients with knee osteoarthritis. ODG states Continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. This meta-analysis showed that cryotherapy has a statistically significant benefit in postoperative pain control, while no improvement in postoperative range of motion or drainage was found. As the cryotherapy apparatus is fairly inexpensive, easy to use, has a high level of patient satisfaction, and is rarely associated with adverse events, we believe that cryotherapy is justified in the postoperative management of surgery. Although the use of equipment is appropriate post-operatively, the medical records neither indicate that this injured worker had any recent surgery nor, is scheduled to have one. As such, there is no indication for use of cold unit at this time. For heat therapy special equipment is not needed. ODG also state mechanical circulating units with pumps have not been proven to be more effective than passive hot and cold therapy. The requested treatment Cold/Heat therapy unit rental is not medically necessary and appropriate.

Lumbar brace: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM 2004 guidelines, page 301 Official Disability Guidelines: Low Back Chapter, Back Braces/Lumbar Supports.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308.

Decision rationale: This request for Back Brace (Lumbar Back Support) is evaluated in light of the MTUS recommendations. As per MTUS-ACOEM lumbar supports have not been shown to have any lasting benefit beyond the acute phase of low back pain. Medical Records of the injured worker indicate chronic low back pain. As per submitted medical records and Guidelines cited, the back brace is not medically necessary and appropriate.

TENS/EMS unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines transcutaneous electrical nerve stimulation (TENS). Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back - Lumbar & Thoracic (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrical nerve stimulation (TENS) Page(s): 115-116.

Decision rationale: As Per CA MTUS guidelines TENS unit is not recommended as a primary modality, but a one month home-based trial may be considered if used as an adjunct to a program of evidence-based functional restoration, with documentation of how often the unit was used. MTUS Guideline does support rental of this unit at the most for one month, but Medical Records are not clear if this injured worker has tried TENS/EMS unit in a supervised setting and was there any functional benefit. A treatment plan that includes the specific short and long term goals of treatment with TENS unit cannot be located in the submitted Medical Records. The Requested Treatment TENS Unit with Garment is not medically necessary and appropriate.