

Case Number:	CM15-0175201		
Date Assigned:	09/17/2015	Date of Injury:	06/17/2015
Decision Date:	11/12/2015	UR Denial Date:	08/03/2015
Priority:	Standard	Application Received:	09/04/2015

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: Arizona, Michigan

Certification(s)/Specialty: Preventive Medicine, Occupational 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 53 year old, female who sustained a work related injury on 6-17-15. The diagnoses have included status post crush injury, rule out cervical intervertebral disc displacement without or with myelopathy, right greater than left arm radiculopathy, contusions both shoulders and chest, rule out lumbar intervertebral disc displacement without myelopathy and bilateral L5 radiculopathy. Treatments have included pain medications. In the progress notes dated 7-23-15, the injured worker reports constant neck pain that radiates into her upper back and left arm. She has tingling as well as loss of grip strength. She rates her pain a 9 out of 10. She reports constant achy pain in both shoulders and chest. She rates this pain a 7 out of 10. She reports low back pain, which radiates into her right greater than left leg. She states she has tingling in both legs with cramping in her right calf. She rates this pain a 9 out of 10. Upon physical exam, she has severe spasms in the cervical paraspinal muscles that go into both trapezius muscles. She has loss of sensation along the C5 nerve distribution on both sides. Muscle strength is decreased to 4+ out of 5 in both arms and 3+ out of 5 muscle strength in biceps and triceps. Shoulders have painful range of motion. She has tenderness to palpation of both sacroiliac joints and both iliac crests. Palpation of both sciatic notches brings about radicular symptoms into the corresponding leg. Lumbar range of motion is too painful to perform. She has positive straight leg raises in both legs. Braggard's sign is positive on both sides. She has loss of sensation in the L5 nerve distribution in both legs. 5-view cervical spine x-rays reveals "loss of cervical lordosis with slight kyphosis. There is multi-level loss of disc height with degenerative changes throughout." 2 view x-rays of both shoulders reveals

"degenerative changes bilaterally." 5 view x-rays of lumbar spine reveals "loss of disc height at L4-L5 and L5-S1." She is not working. The treatment plan includes requests for authorization for MRIs of cervical and lumbar spine, for EMG-NCV studies of bilateral upper and lower extremities, for a pain management consult and treat, for acupuncture and for a TENS unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electromyograph (EMG) and nerve conduction velocity (NCV) of bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic)/ Electrodiagnostic studies, Nerve conduction studies.

Decision rationale: Per ACOEM in the MTUS, most patients presenting with true neck and upper back problems do not need special studies until a 3-4 week period of conservative care fails to improve symptoms, most patients improve quickly once red-flag conditions are ruled out. Criteria for ordering imaging studies are emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery and clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurological examination is less clear, however further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. EMG and NCV may help identify subtle focal neurologic dysfunction in patients with neck and or arm symptoms lasting more than 3-4 weeks. Per the ODG, NCS are not recommended to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but recommended if the EMG is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely based on the clinical exam. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy. While cervical electrodiagnostic studies are not necessary to demonstrate a cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality, diabetic neuropathy, or some problem other than a cervical radiculopathy, with caution that these studies can result in unnecessary over treatment. A review of the injured workers medical records reveal that the mechanism of injury and radiculopathy is already clinically obvious. It is not clear how obtaining electrodiagnostic studies will change the management of this patient, therefore the request for Electromyograph (EMG) and nerve conduction velocity (NCV) of bilateral upper extremities is not medically necessary.

Electromyograph (EMG) and nerve conduction velocity (NCV) of bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic) / Electrodiagnostic Studies, (EMG) Electromyography, Nerve Conduction Studies (NCS).

Decision rationale: Per the MTUS, EMG may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than 3-4 weeks. Per the ODG, EMG's are not necessary if radiculopathy is already clinically obvious. NCS are not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. EMG/nerve conduction studies (NCS) often have low combined sensitivity and specificity in confirming root injury, and there is limited evidence to support the use of often uncomfortable and costly EMG/NCS. A review of the injured workers medical records reveal that the mechanism of injury and radiculopathy is already clinically obvious. It is not clear how obtaining electrodiagnostic studies will change the management of this patient, therefore the request for Electromyograph (EMG) and nerve conduction velocity (NCV) of bilateral lower extremities is not medically necessary.

8 acupuncture sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment 2007.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment 2007.

Decision rationale: The MTUS recommends acupuncture as an option when pain medication is reduced or not tolerated, and it may be used as an adjunct to physical rehabilitation and or surgical intervention to hasten functional recovery. Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient and reduce muscle spasm. Time to produce functional improvement is 3-6 treatments. 1-3 times a week for 1-2 months. Per the ODG, acupuncture is not recommended for neck pain. Despite substantial increases in its popularity and use, the efficacy of acupuncture for chronic mechanical neck pain remains unproven. Acupuncture reduces neck pain and produces a statistically, but not clinically, significant effect compared with placebo. This passive intervention should be an adjunct to active rehab efforts. ODG Acupuncture Guidelines: Initial trial of 3-4 visits over 2 weeks. With evidence of objective functional improvement, total of up to 8-12 visits over 4-6 weeks. (Note: The evidence is inconclusive for repeating this procedure beyond an initial short course of therapy.) A review of the injured workers medical records reveal that she has already been evaluated for acupuncture however, it is not clear if she had any sessions and if she had any improvement in pain and function as a result, without this information it is not possible to establish medical necessity. Therefore, the request for 8 acupuncture sessions is not medically necessary.

TENS unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: Per the MTUS, transcutaneous electrotherapy is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. The MTUS criteria for the use of TENS: Chronic intractable pain, documentation of pain of at least three months duration, evidence that other appropriate pain modalities have been tried (including medication) and failed. A one-month trial period of the TENS unit should be documented (as an adjunct to ongoing 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; rental would be preferred over purchase during this trial. Other ongoing pain treatment should also be documented during the trial period including medication usage. A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted. A 2-lead unit is generally recommended; if a 4-lead unit is recommended, there must be documentation of why this is necessary. A review of the injured workers medical records did not reveal a one-month trial with the appropriate documentation as recommended by the MTUS and without this information, the request is not medically necessary.