

Case Number:	CM15-0179367		
Date Assigned:	09/21/2015	Date of Injury:	06/30/2015
Decision Date:	10/23/2015	UR Denial Date:	08/25/2015
Priority:	Standard	Application Received:	09/11/2015

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: Texas, Florida, California
 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:

This is a 33 year old female with a date of injury on 6-30-2015. A review of the medical records indicates that the injured worker is undergoing treatment for cervical radiculopathy and lumbosacral radiculopathy. According to the initial orthopedic evaluation dated 7-30-2015, the injured worker complained of daily headaches as well as migraines. She complained of continuous, moderate aching pain in her neck, at times becoming sharp and stabbing, worse on the left side. She reported tingling and burning sensations in the left side of the neck. The pain radiated down into the arm and hand and down into the shoulder blades. She complained of muscle spasms, stiffness and restricted range of motion in her head and neck. She also complained of pain in the upper and mid back continuously, along with muscle spasms, numbness and tingling. The physical exam (7-30-2015) revealed spasm and tenderness over the paravertebral musculature and upper trapezius on the left. Cervical range of motion was noted to be normal. Decreased sensation was noted in the left C5 and C6 dermatomes with pain. Cervical range of motion was accomplished with discomfort and spasm. Exam of the lumbar spine revealed tenderness and spasm in the paravertebral muscle. Treatment has included physiotherapy and medications. Current medications (7-30-2015) included Tizanidine, Magox and Vitamin B2. Per the treating physician (7-30-2015), the injured worker stated that "there have been only a few physiotherapy sessions and that these were largely passive in nature." Magnetic resonance imaging (MRI) of the cervical spine dated 6-17-2015 showed straightening of the normal cervical lordosis. Retrolisthesis seen on plain film was not identified on magnetic resonance. There were minimal disc osteophyte complexes and uncovertebral hypertrophy from

C3-C4 through C5-C6. There was mild left foraminal stenosis at C3-C4 appear minimal left foraminal stenosis at C5-C6. The original Utilization Review (UR) (8-25-2015) denied requests for electromyography (EMG)-nerve conduction velocity (NCV) of the bilateral upper extremities and physio-therapy three times a week for four weeks for the cervical spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV of the bilateral upper extremities: Upheld

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

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods.

Decision rationale: Key case points are as follows. The claimant was injured in 2015, the injured worker complained of daily headaches as well as migraines. She complained of continuous, moderate aching pain in her neck. Decreased sensation was noted in the left C5 and C6 dermatomes with pain. Treatment has included physiotherapy and medications. The MTUS ACOEM notes that electrodiagnostic studies may be used when the neurologic examination is unclear, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. In this case, it is not clear why bilateral studies are needed, when symptoms are on just one side. The request is not medically necessary.

Physio-therapy 3 times 4 weeks-cervical: Upheld

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

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

Decision rationale: Chronic Pain Medical Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009), page 98 of 127. Key case points are as follows. The claimant was injured in 2015, the injured worker complained of daily headaches as well as migraines. She complained of continuous, moderate aching pain in her neck. Decreased sensation was noted in the left C5 and C6 dermatomes with pain. Treatment has included physiotherapy and medications. The MTUS does permit physical therapy in chronic situations, noting that one should allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. The conditions mentioned are Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks; Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks; and Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. This claimant does not have these conditions. And, after several documented sessions of therapy, it is not clear why the patient would not be independent with self-care at this point. Also, there are especially strong caveats in the MTUS/ACOEM

guidelines against over treatment in the chronic situation supporting the clinical notion that the move to independence and an active, independent home program is clinically in the best interest of the patient. They cite: Although mistreating or under treating pain is of concern, an even greater risk for the physician is over treating the chronic pain patient. Over treatment often results in irreparable harm to the patient's socioeconomic status, home life, personal relationships, and quality of life in general. A patient's complaints of pain should be acknowledged. Patient and clinician should remain focused on the ultimate goal of rehabilitation leading to optimal functional recovery, decreased healthcare utilization, and maximal self actualization. This request is not medically necessary.