

Case Number:	CM15-0064548		
Date Assigned:	04/10/2015	Date of Injury:	07/17/2013
Decision Date:	06/08/2015	UR Denial Date:	03/30/2015
Priority:	Standard	Application Received:	04/06/2015

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 (IW) is a 52-year-old male who sustained an industrial injury on 07/17/2013. The mechanism of injury was the injured worker was picking up a piece of metal or aluminum weighing approximately 50 pounds and as he lifting it, he felt a pop in his back. The injured worker was diagnosed as having lumbar degenerative scoliosis; pre-existing and quiescent; Lumbosacral sprain /strain superimposed on #1, resolving; Intermittent right lower extremity radiculopathy, quiescent; Lumbar degenerative disc disease, multilevel and pre-existing. Treatment to date has included physical therapy, a lumbar brace, a home exercise program, radiofrequency ablation, lumbar facet steroid injections, MRI, radiographs, and the use of ice and heat to the affected area. The documentation of 01/07/2015 revealed the injured worker had back pain that was radicular in nature. The injured worker's pain was 7/10. The pain was relieved with medications, rest, and activity restrictions. The injured worker underwent 2 back surgeries in 2014. The physical examination revealed tenderness to palpation of the lumbar paraspinal muscles and over the lumbosacral junction. There was decreased range of motion of the lumbar spine. The injured worker had decreased sensation to pinprick and light touch at the L4, L5, and S1 dermatomes bilaterally. The motor strength was 4/5 in all represented muscle groups in the bilateral lower extremities. The treatment plan included medications, x-rays of the lumbar spine, an MRI of the lumbar spine, an EMG/NCV of the bilateral lower extremities, physical therapy, chiropractic care, acupuncture 3 times a week for 6 weeks, shockwave therapy up to 6 treatments for the lumbar spine, a TENS unit, hot and cold units, and Terocin patches. The following procedures were requested: MRI L/S (lumbar spine), EMG NCV bilateral upper

and lower extremities, Chiropractic 2x4, Physical therapy 2x4, Acupuncture 2x4, and Shockwave.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI L/S (lumbar spine): 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 may be appropriate for an injured worker who has a significant change in symptoms or findings of a significant pathology. The clinical documentation submitted for review indicated the injured worker had previously undergone MRIs of the lumbar spine. The clinical documentation submitted for review failed to indicate the injured worker had a significant change in symptoms or a significant objective finding to support the necessity. Given the above, the request for an MRI of the lumbar spine is not medically necessary.

EMG NCV bilateral upper and lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Official Disability Guidelines, Pain chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 177-179, 303-305. 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), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. There should be documentation of 3 - 4 weeks of conservative care and observation. The clinical documentation submitted for review failed to provide documentation of objective findings related to the bilateral upper extremities. This portion of the request would not be supported. Additionally, there was a lack of documentation of a failure of conservative care for the upper extremities. 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 based on 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 NCS. The clinical documentation submitted for review indicated the injured worker had decreased sensation to pinprick and light touch at the L4, L5, and S1 dermatomes bilaterally and decreased motor strength. However, there was a lack of documentation of a failure of conservative care for the lower extremities. Given the above, the request for an EMG/NCV of the bilateral upper and lower extremities is not medically necessary.

Chiropractic 2x4: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 58-59.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy Page(s): 58, 59.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines state that manual therapy and manipulation is recommended for chronic pain if caused by musculoskeletal conditions. For the low back, therapy is recommended initially in a therapeutic trial of 6 sessions and with objective functional improvement, a total of up to 18 visits over 6-8 weeks may be appropriate. Treatment for flare-ups requires a need for re-evaluation of prior treatment success. Treatment is not recommended for the ankle & foot, carpal tunnel syndrome, the forearm, wrist, & hand or the knee. If chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 visits. Treatment beyond 4-6 visits should be documented with objective improvement in function. The maximum duration is 8 weeks and at 8 weeks patients should be re-evaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain and improving quality of life. The clinical documentation submitted for review failed to provide documentation of exceptional factors to support the necessity for 8 visits as the initial visits would be 6. The request as submitted failed to indicate the body part to be treated. Given the above, and the lack of documentation of exceptional factors, the request for chiropractic 2 times 4 is not medically necessary.

Physical therapy 2x4: Upheld

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

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

Decision rationale: The California MTUS Guidelines recommend physical medicine treatment for myalgia, myositis, and radiculitis for up to 10 sessions. The clinical documentation submitted for review indicated the injured worker had previously been treated with physical

medicine. There was a lack of documentation of objective functional benefit that was received and the specific quantity of sessions. There was a lack of documentation of remaining objective functional deficits. Additionally, the request as submitted failed to indicate the body part to be treated. Given the above, the request for physical therapy 2 times 4 is not medically necessary.

Acupuncture 2x4: 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. 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. 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 to support a necessity for 8 sessions, which would exceed guideline recommendations. The request as submitted failed to indicate the body part to be treated with acupuncture. Given the above, the request for acupuncture 2 times 4 is not medically necessary.

Shockwave: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, updated on 03/24/15, Online version, Shock wave therapy.

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, Shockwave.

Decision rationale: The Official Disability Guidelines indicate that shockwave therapy is not recommended for the lumbar spine. There was a lack of documentation of exceptional factors to warrant non-adherence to guideline recommendations. The documentation indicated the request was for treatment of the lumbar spine. The request as submitted failed to indicate the body part and frequency as well as duration. Given the above, the request for shockwave is not medically necessary.