Case Number:	CM16-0230651		
Date Assigned:	12/07/2016	**Date of Injury:**	10/13/2016
Decision Date:	01/09/2017	**UR Denial Date:**	11/22/2016
Priority:	Standard	**Application Received:**	11/29/2016

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,Washington
Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 case involves a now 36-year-old female with a history of an occupational claim from 10/13/2016. The mechanism of injury is detailed as a slip and fall. The current diagnosis is documented as other intervertebral disc displacement, lumbosacral region. A CT of the thoracic spine, dated 10/28/2016, revealed unremarkable thoracic spine CT. Treatment to date includes medications. On 11/10/2016, the patient presented with consistent, severe and constant bilateral neck and low back pain. The pain was rated 10/10 on VAS, and the patient reported difficulty with sleep. Physical exam of the lumbar spine revealed a no gross abnormality. Lumbar lordosis was normal. Straight leg raise examination was positive in bilateral legs. Lumbar range of motion was decreased. Deep tendon reflexes were 2/2, and motor strength was 5-/5 in bilateral legs. The treatment plan includes EMG/NCV of lower and upper extremities to confirm and rule out possibility of neuropathy. The patient was also recommended acupuncture, MRI of the lumbar spine, chiropractic treatment, physical therapy, Ultram 50 mg, naproxen 500 mg, and Flexeril 10 mg. The patient's current medication regimen was not provided. A Request for Authorization, dated 11/15/2016, was provided. The original utilization review dated 11/22/2016 denied the request for electrodiagnostic studies and MRI of the lumbar spine, due to there was no evidence the patient has tried and failed conservative care. The request for chiropractic care was denied due to the guidelines do not support multiple physical modalities being performed concurrently. The concurrent request for physical therapy was modified. The request for physical therapy was modified for an initial trial. The request for Ultram 50 mg was denied due to there was no documentation that alternative treatments have been considered. The request for

naproxen 500 mg was approved. The request for Flexeril 10 mg was denied due to there was no documentation of the intention to treat over a short course.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV of the lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016, Section(s): Electrodiagnostic testing (EMG/NCS). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016, Section(s): Electrodiagnostic testing (EMG/NCS).

Decision rationale: The California MTUS 2016 Chronic Pain Guidelines state, electromyography and nerve conduction studies are separate studies, and should not necessarily be done together. Nerve conduction studies in the lower extremities are not recommended, but electromyography is recommended as an option to obtain unequivocal evidence of radiculopathy, after one month conservative therapy, but electromyography is not necessary if radiculopathy is already clinically obvious. There is a lack of evidence based rationale provided by the physician as to the medical necessity for diagnostic testing at this time. The patient has not trialed and failed a proper conservative course of care prior to this request. Furthermore, medical necessity for a nerve conduction study is not supported. There are no exceptional factors noted within the documentation which would demonstrate medical necessity for the requested treatment outside of the recommended guidelines. Given the above, the request for EMG/NCV of the lower extremities is not medically necessary.

EMG/NCV of the upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016, Section(s): Electrodiagnostic testing (EMG/NCS). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016, Section(s): Electrodiagnostic testing (EMG/NCS).

Decision rationale: The California MTUS 2016 Chronic Pain Guidelines state, electromyography and nerve conduction studies are separate studies, and should not necessarily be done together. Nerve conduction studies are recommended in patients with clinical signs of carpal tunnel syndrome who may be candidates for surgery, but electromyography is generally not necessary. There is a lack of evidence based rationale provided by the physician as to the medical necessity for this request. There was no evidence the patient has trialed and failed a proper conservative course of care prior to proceeding with diagnostic testing. Furthermore, physical exam revealed no evidence of clinical signs consistent with carpal tunnel syndrome. There was no indication the patient is a candidate for surgery. The request for electromyography

is not supported. There are no exceptional factors noted within the documentation which would demonstrate medical necessity for the requested treatment outside of the recommended guidelines. Given the above, the request for EMG/NCV of the upper extremities is not medically necessary.

Electro acupuncture to the low back two times a week times six weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment 2007.

Decision rationale: The California MTUS Acupuncture Guidelines recommend acupuncture as an option when pain medication is reduced or not tolerated, and may be used as an adjunct to physical rehabilitation, and/or surgical intervention to hasten functional recovery. There is a lack of evidence based rationale provided by the physician as to the medical necessity for this request. The patient presented with pain rated 10/10 on VAS. The current medication regimen was not provided. There was no indication that pain medication is being reduced or not tolerated to warrant the requested treatment. Additionally, the request for an initial 12 sessions exceeds the recommended guidelines. The guidelines recommend 3 to 6 treatments to produce functional improvement. There are no exceptional factors noted within the documentation which would demonstrate medical necessity for the requested treatment outside of the recommended guidelines. Given the above, the request for Electro acupuncture to the low back two times a week times six weeks is not medically necessary.

Infrared heat to the low back two times a week times six weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment 2007.

Decision rationale: The California MTUS Acupuncture Guidelines recommend acupuncture as an option when pain medication is reduced or not tolerated, and may be used as an adjunct to physical rehabilitation, and/or surgical intervention to hasten functional recovery. There is a lack of evidence based rationale provided by the physician as to the medical necessity for this request. The patient presented with pain rated 10/10 on VAS. The current medication regimen was not provided. There was no indication that pain medication is being reduced or not tolerated to warrant the requested treatment. Additionally, the request for an initial 12 sessions exceeds the recommended guidelines. The guidelines recommend 3 to 6 treatments to produce functional improvement. There are no exceptional factors noted within the documentation which would demonstrate medical necessity for the requested treatment outside of the recommended guidelines. Given the request for acupuncture is not supported the requested modalities are not indicated at this time. As such, the request for Infrared heat to the low back two times a week times six weeks is not medically necessary.

Myofascial release to the low back two times a week times six weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment 2007.

Decision rationale: The California MTUS Acupuncture Guidelines recommend acupuncture as an option when pain medication is reduced or not tolerated, and may be used as an adjunct to physical rehabilitation, and/or surgical intervention to hasten functional recovery. There is a lack of evidence based rationale provided by the physician as to the medical necessity for this request. The patient presented with pain rated 10/10 on VAS. The current medication regimen was not provided. There was no indication that pain medication is being reduced or not tolerated to warrant the requested treatment. Additionally, the request for an initial 12 sessions exceeds the recommended guidelines. The guidelines recommend 3 to 6 treatments to produce functional improvement. There are no exceptional factors noted within the documentation which would demonstrate medical necessity for the requested treatment outside of the recommended guidelines. Given the request for acupuncture is not supported the requested modalities are not indicated at this time. As such, the request for Myofascial release to the low back two times a week times six weeks is not medically necessary.

MRI of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter.

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

Decision rationale: The ACOEM Guidelines state, unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment, and who would consider surgery an option. Based on the clinical notes submitted for review, the patient presented with continued complaints of pain in the cervical/lumbar spine. However, there was no documentation the patient has trialed and failed a proper conservative course of care prior to proceeding with diagnostic testing. There is a lack of evidence based rationale provided by the physician as to the medical necessity for this request at this time, prior to completion of conservative care. There is no evidence of red flags for serious spinal pathology to warrant the requested imaging. Given the above, the request for MRI of the lumbar spine is not medically necessary.

Chiropractic care to the low back two times a week for four weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016, Section(s): Manual therapy & manipulation.

Decision rationale: The California MTUS 2016 Chronic Pain Guidelines recommend chiropractic treatment for chronic pain if caused by musculoskeletal conditions, and only when manipulation is specifically recommended by the provider in the plan of care. The patient was recommended chiropractic treatment due to recent work injury affecting the patient's cervical/lumbar spine. The patient reported pain rated 10/10 on VAS. Current alleviating factors were not provided. However, the patient's concurrent request for physical therapy was modified by previous reviewer. Multiple physical modalities being performed at the same time is not supported. Additionally, the request for an initial 8 sessions exceeds the recommended guidelines. The guidelines recommend 4 to 6 treatments to produce effect. Given the above, the request for Chiropractic care to the lo9w back two times a week for four weeks is not medically necessary.

Ultram 50mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Opioid Treatment 2016.

MAXIMUS guideline: Decision based on MTUS Opioid Treatment 2016, Section(s): 3.3 Opioids for Chronic Pain and Chronic Opioid Treatment: Initiating and Monitoring Chronic Opioid Treatment.

Decision rationale: The California MTUS Opioid Treatment Guidelines recommend screening for risk of addiction or adverse events, prior to chronic opioid treatment. There is a lack of evidenced rationale provided by the physician as to the medical necessity for initiating opioid therapy at this time. The patient's current medication regimen is not provided. A screening for risk of addiction was also not completed. There was no indication the patient has trialed and failed non-opioid analgesics prior to this request. Given the above, the request for Ultram 50mg #30 is not medically necessary. This decision addresses the medical necessity of opioids as they have been prescribed to this patient. This medical necessity decision should not be interpreted as a recommendation to stop long-term opioids abruptly and the patient is advised to speak with their treating physician. The treating physician and the patient are advised to consult the MTUS Opioids Treatment Guidelines ("Tapering opioids"), and if necessary, other relevant guidelines, regarding the most appropriate method for weaning and terminating opioids for this patient.

Flexeril 10mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016, Section(s): Muscle relaxants (for pain). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016, Section(s): Cyclobenzaprine (Flexeril).

Decision rationale: The California MTUS 2016 Chronic Pain Guidelines recommend cyclobenzaprine using a short course of therapy. This medication is not recommended for longer than 2 to 3 weeks. Physical exam revealed no evidence of acute muscle spasms. The request for quantity 60 exceeds the recommended guidelines. This medication is only recommended for a

short course. There were no exceptional factors noted within the documentation which would demonstrate medical necessity for the requested treatment outside of the recommended guidelines. Given the above, the request for Flexeril 10mg #60 is not medically necessary.

Physical therapy to the low back eight sessions was the original request. Physical therapy to the low back six sessions was authorized by the Claims Administrator. The remaining IMR eligible portion of the original request, Physical therapy to the low back two sessions is: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016, Section(s): Physical medicine treatment.

Decision rationale: The California MTUS 2016 Chronic Pain Guidelines recommend physical therapy for restoring flexibility, strength, endurance, function, range of motion, and alleviate discomfort. The patient presented with complaints of cervical/lumbar spine pain rated 10/10 on VAS. There was decreased motor strength, and decreased range of motion noted. The patient was authorized an initial trial of 6 sessions by previous reviewer. Medical necessity for additional therapy is not substantiated at this time. Additional therapy is contingent upon patient response to treatment. Given the above, the request for physical therapy to the low back, 2 sessions, is not medically necessary.