

<b>Case Number:</b>	CM13-0063390		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	06/28/2012
<b>Decision Date:</b>	04/14/2014	<b>UR Denial Date:</b>	11/13/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/10/2013

### 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. The expert reviewer is Board Certified in Family Practice and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is an 80-year-old female who reported an injury on 06/28/2012. The mechanism of injury involved a fall. The patient is currently diagnosed with contusion of the hip. The patient was seen by [REDACTED] on 06/07/2013. The patient reported 8/10 lower back pain with 6/10 right knee pain. Physical examination revealed tenderness to palpation of the lumbosacral region with 50% normal range of motion, intact sensation and 5/5 motor strength in the bilateral lower extremities. Treatment recommendations included an appeal request for an EMG/NCV study, continuation of heat and exercise program, and water therapy twice per week for 6 weeks.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **EVALUATION AND AQUA THERAPY FOR TO THORACIC/RIGHT KNEE/LEG 2 TIMES PER WEEK FOR 4 WEEKS: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22.

**Decision rationale:** The California MTUS Guidelines state that aquatic therapy is recommended as an optional form of exercise therapy, where available as an alternative to land-based physical

therapy. As per the documentation submitted, the patient's physical examination revealed tenderness to palpation with 50% normal range of motion. The patient demonstrated intact sensation and 5/5 motor strength. There was no indication that this patient required reduced weightbearing as opposed to land-based physical therapy. Therefore, the request is non-certified.

**SPECIALTY CONSULT:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, Chapter 7, page 127

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state that referral may be appropriate if the practitioner is uncomfortable with the line of inquiry, with treating a particular cause of delayed recovery or has difficulty obtaining information or an agreement to a treatment plan. As per the documentation submitted, the patient's physical examination only revealed tenderness to palpation with 50% normal range of motion. There was no documentation of a significant musculoskeletal or neurological deficit. There was also no evidence of an exhaustion of conservative care prior to the request for a specialty referral. The medical necessity has not been established. Therefore, the request is non-certified.

**ELECTROMYOGRAM (EMG), WITH CONSULT, FOR THE BILATERAL LOWER EXTREMITY:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state that electromyography, including H-reflex tests, may be useful to identify subtle, focal neurological dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks. As per the documentation submitted, the patient demonstrated intact sensation and 5/5 motor strength in the bilateral lower extremities. The patient demonstrated 2+ deep tendon reflexes and negative special testing. The medical necessity for the requested procedure has not been established. Therefore, the request is non-certified.

**NERVE CONDUCTION VELOCITY (NCV), WITH CONSULT, FOR THE BILATERAL LOWER EXTREMITY:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints  
Page(s): 303-305.

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state that electromyography, including H-reflex tests, may be useful to identify subtle, focal neurological dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks. As per the documentation submitted, the patient demonstrated intact sensation and 5/5 motor strength in the bilateral lower extremities. The patient demonstrated 2+ deep tendon reflexes and negative special testing. The medical necessity for the requested procedure has not been established. Therefore, the request is non-certified.