

Case Number:	CM13-0068935		
Date Assigned:	07/02/2014	Date of Injury:	07/11/2013
Decision Date:	08/12/2014	UR Denial Date:	12/19/2013
Priority:	Standard	Application Received:	12/20/2013

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 Physical Medicine and Rehabilitation and is licensed to practice in California. 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 injured worker is a 54-year-old female who reported an injury on 07/11/2013 while assisting a patient out of bed. The injured worker complained of low back pain with the pain being worse on the right than left. On a scale of 1-10 the injured worker rated the pain at 8/10. Within the physical examination dated 10/22/2013, strength was noted as right quadriceps 4+/5, right eversion 4+/5, left quadriceps 4+/5, left eversion 5-/5. There was diminished sensation in the right L4, L5, and S1 dermatomal distributions. There was a positive straight leg raise on the right for pain to the foot at 35 degrees and on the left for pain to the mid-calf at 45 degrees. The injured worker's diagnoses were anteriorlithesis 3 mm L4 on L5 with a protrusion of 3 mm at L5 to S1 with mild foraminal narrowing, right greater than left; facet arthropathy at L3-4, L4-5, L5-S1; and reactive depression/anxiety. Past treatments and diagnostics was an MRI of the lumbar spine dated 08/21/2013 demonstrated facet hypertrophy at L3-4, L4-5 and L5-S1. There is a 3 mm anterolisthesis of the L4 on L5. There is a 3 mm disc protrusion at the L5 to S1 with mild neural foraminal narrowing right greater than left, with the disc material abutting the exiting nerve root on the right. The injured worker's medications included naproxen 550 mg and cyclobenzaprine 7.5 mg. Rationale for request was given the nature of the injured worker's condition in regards to progressive neurological deficit. The Request for Authorization form was not provided in the documentation for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG OF BILATERAL LOWER EXTREMITIES: Upheld

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

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

Decision rationale: The request for electromyography of bilateral lower extremity quantity 1 is not medically necessary. The California MTUS/ACOEM Guidelines state 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 despite conservative treatment. There was clinical documentation of neurological examination, in the lower extremities demonstrates right quadriceps 4+/5, right eversion 4+/5, left quadriceps 4+/5, left eversion 5-/5. There was diminished sensation in the right L4,L5, and S1 dermatomal distributions. There was a positive straight leg raise on the right for pain to the foot at 35 degrees and on the left for pain to the mid calf at 45 degrees. Although the injured worker had low back symptoms over 3 weeks with conservative care and there was clinical documentation of specific neurological deficits in the right lower extremity with diminished dermatomal distributions. There was no evidence of left sided neurological deficit to warrant a EMG of bilateral lower extremities. As such, the request for electromyography of bilateral lower extremity quantity 1 is not medically necessary.

NCV of Right Lower Extremity: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG- Low Back Section.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low Back, Nerve Conduction Studies.

Decision rationale: The request for NCV of right lower extremity quantity 1 is not medically necessary. The ODG states that nerve conduction study is not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. The injured worker complained of weakness and decreased sensation in the right lower extremity. However, the examination findings did not reveal evidence of peripheral neuropathy to support an NCV study. Therefore, the request for NCV of the right lower extremity quantity 1 is not medically necessary.

NCV of Left Lower Extremity: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low Back Section.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low Back, Nerve Conduction Studies.

Decision rationale: The request for NCV of right lower extremity quantity 1 is not medically necessary. The ODG states that nerve conduction study is not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. There is no objective clinical documentation of peripheral neuropathy or neurological deficits in the left lower extremity to support the requested NCV of the left lower extremity. Therefore, the request for NCV of the right lower extremity quantity 1 is not medically necessary.

Physical Therapy For Lumbar Spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Physical Therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

Decision rationale: The request for physical therapy for lumbar spine quantity 12 is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines states that active therapy requires an internal effort by the individual to complete, a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process, in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. Physical medicine guidelines allow for fading of treatment frequency, plus self-directed home physical medicine. Neuralgia, neuritis, and radiculitis unspecified 8-10 visits over 4 weeks. There was no functional deficits documented. However, details regarding the injured worker's prior treatment, including number of visits completed, and objective functional gains obtained, were not provided. Based on the lack of objective evidence of functional improvement with previous visits, the appropriateness of additional physical therapy cannot be established. Furthermore, the request failed to indicate the number of visits planned. Therefore, despite evidence of current objective functional deficits in lumbar spine, due to the lack of documentation regarding previous physical therapy and the specific number of visits being requested, the request is not supported. As such, the request for physical therapy for lumbar spine is not medically necessary.