

Case Number:	CM14-0003064		
Date Assigned:	01/31/2014	Date of Injury:	08/22/2012
Decision Date:	09/30/2014	UR Denial Date:	12/09/2013
Priority:	Standard	Application Received:	01/08/2014

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 Anesthesiology, has a subspecialty in Pain Medicine 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 injured worker is a 76 year old male whose date of injury is 08/22/2012. The mechanism of injury is described as a slip and fall down a wet floor/ramp. Treatment to date includes 12 sessions of physical therapy without benefit, ice/heat, single-point cane and medication management. The injured worker returned to regular work duty on 10/31/12, but subsequently returned to modified duty on 11/29/12. The injured worker has not worked since January 2013. Note dated 10/30/13 indicates that the injured worker completed 12 visits of physical therapy without benefit. Assessment includes cervical spine strain, lumbar strain versus radiculopathy, left hip degenerative joint disease, and impingement syndrome of the left shoulder. Acupuncture progress note dated 01/23/14 indicates that the injured worker complains of back, shoulder and hip pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG (ELECTROMYOGRAPHY) FOR LUMBAR SPINE AND RIGHT LOWER EXTREMITY,: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301-303.

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

Decision rationale: Based on the clinical information provided, the request for EMG for lumbar spine and right lower extremity is not recommended as medically necessary. ACOEM guidelines note 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. There is no current, detailed physical examination submitted for review to support the requested study. Therefore, EMG (Electromyography) for Lumbar Spine and Right Lower Extremity is not medically necessary.

NCS (NERVE CONDUCTION STUDIES) FOR LUMBAR SPINE AND RIGHT LOWER EXTREMITY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301,303,Chronic Pain Treatment Guidelines 11-1, 16-17, 78, 93-94, 98-99, 112, 114-116.

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

Decision rationale: Based on the clinical information provided, the request for NCS for lumbar spine and right lower extremity is not recommended as medically necessary. ACOEM guidelines note 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. There is no current, detailed physical examination submitted for review to support the requested study. Therefore, NCS (Nerve Conduction Studies) For Lumbar Spine and Right Lower Extremity is not medically necessary.

SIX (6) PHYSICAL THERAPY SESSIONS FOR LUMBAR SPINE.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99.

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, Physical therapy.

Decision rationale: Based on the clinical information provided, the request for 6 physical therapy sessions for the lumbar spine is not recommended as medically necessary. The submitted records indicate that the injured worker has completed 12 physical therapy visits to date without benefit. The Official Disability Guidelines support up to 10 sessions of physical therapy for the patient's diagnosis, and there is no clear rationale provided to support exceeding this recommendation. There are no exceptional factors of delayed recovery documented. There is no current, detailed physical examination submitted for review, and no specific, time-limited treatment goals were provided. Therefore, Physical Therapy Sessions for Lumbar Spine is not medically necessary.

LUMBAR BRACE: 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, Lumbar support.

Decision rationale: Based on the clinical information provided, the request for lumbar brace is not recommended as medically necessary. The Official Disability Guidelines report that lumbar supports are not recommended for prevention of low back pain. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain. There is no documentation of compression fractures, spondylolisthesis, or documented instability. Therefore, Lumbar Brace is not medically necessary.

VOLTAREN CREAM: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

Decision rationale: Based on the clinical information provided, the request for Voltaren cream is not recommended as medically necessary. The MTUS guidelines note that Voltaren gel is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). The injured worker complains primarily of pain to the low back, left shoulder and bilateral hip. Therefore, MTUS criteria are not met, and the requested Voltaren cream is not medically necessary.