

Case Number:	CM14-0003343		
Date Assigned:	01/31/2014	Date of Injury:	05/07/2007
Decision Date:	06/23/2014	UR Denial Date:	12/19/2013
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 Physical Medicine & Rehabilitation 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 51-year-old male who reported an injury on 05/07/2007. The mechanism of injury was not provided for review. The injured worker's treatment history included laminectomy and decompression at L5-S1 and fusion surgery from C4 to C7. The cervical spine surgery was in 09/2013. The injured worker was evaluated on 11/18/2013. It was documented that the injured worker had increasing low back pain radiating into the bilateral lower extremities. Physical findings included tenderness to palpation over the paravertebral cervical musculature. Evaluation of the lumbar spine concluded that there was tenderness to palpation of the distal lumbar segments with painful range of motion and a positive seated nerve root test with disturbed sensation in the L5-S1 dermatomal distribution. The injured worker's diagnoses included status post posterior C4-7 hybrid cervical reconstruction, status post left L5-S1 laminectomy and decompression, internal derangement of the right shoulder, and bilateral cubital tunnel syndrome. The injured worker's treatment plan included MRI of the lumbar spine, EMG/NCV of the bilateral lower extremities, and muscular injection. A request was also made for additional postsurgical physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI OF THE LUMBAR SPINE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM GUIDELINES, LOW BACK

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

Decision rationale: The clinical documentation submitted for review does indicate that the injured worker has previously undergone surgical intervention of the lumbar spine. However, it is unclear when that surgical intervention took place. The clinical documentation does not specifically address prior imaging studies. American College of Occupational and Environmental Medicine do recommend imaging studies for clinically evident neurological compromise that is recalcitrant to conservative treatment. The clinical documentation does not clearly identify what types of conservative treatments have been administered to the patient postsurgically. Additionally, there is no documentation of a significant change in the injured worker's clinical presentation to support the need for additional imaging. As such, the requested MRI of the lumbar spine is not medically necessary or appropriate.

EMG OF THE BILATERAL LOWER EXTREMITIES: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM GUIDELINES, LOW BACK CHAPTER

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

Decision rationale: The requested EMG of the bilateral lower extremities is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine does not support the need for electrodiagnostic studies in the presence of clinically evident neurological compromise. The clinical documentation submitted for review does indicate that the injured worker has a positive seated nerve root test and disturbed sensation in the L5-S1 dermatomal distributions. Therefore, the need for an electrodiagnostic study is not clearly indicated. As such, the requested EMG of the bilateral lower extremities is not medically necessary or appropriate.

CONTINUE POST-OP PHYSICAL THERAPY TO THE CERVICAL SPINE, #8: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM GUIDELINES

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

Decision rationale: The requested continued postoperative physical therapy to the cervical spine #8 is not medically necessary or appropriate. The clinical documentation does indicate that the injured worker has recently undergone cervical spine fusion. California Medical Treatment Utilization Schedule recommends up to 24 visits in the postsurgical management following a fusion. However, the clinical documentation fails to specify how many treatments the injured

worker has already participated in. Additionally, there is no documentation to support the efficacy of prior treatments. In the absence of this information, there is no way to determine the appropriateness of continued postoperative physical therapy. As such, the requested continued post-op physical therapy to the cervical spine #8 is not medically necessary or appropriate.

TENS UNIT, PURCHASE: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines TENS Unit Page(s): 114.

Decision rationale: The requested TENS unit for purchase is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends a 30-day clinical trial that produces functional benefit and symptom response to support the purchase of a TENS unit. The clinical documentation does not provide any evidence that the injured worker has undergone a 30-day clinical trial. Therefore, the purchase of a TENS unit would not be supported. As such, the requested TENS unit for purchase is not medically necessary or appropriate.