

Case Number:	CM14-0005586		
Date Assigned:	02/07/2014	Date of Injury:	04/23/1979
Decision Date:	06/20/2014	UR Denial Date:	12/27/2013
Priority:	Standard	Application Received:	01/13/2014

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 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 patient is a 61-year-old male who has submitted a claim for lumbago, lumbosacral spondylosis without myelopathy, thoracic or lumbosacral neuritis or radiculitis, unspecified, and chronic pain syndrome associated with an industrial injury date of April 23, 1979. The patient complains of worsening bilateral low back pain and numbness and tingling in bilateral lower extremities. Other complaints include intermittent tightness of the low back, sharp pain in the feet and cramping in bilateral legs. Physical examination showed an antalgic, hip-flexed and wide-based gait; limitation of motion and tenderness over the lumbar paraspinal muscles; numbness of the bilateral legs from the groin down, worse on the medial side; and trace DTRs in bilateral lower extremities. The diagnoses include chronic pain syndrome, chronic postoperative pain, post-surgical syndrome, lumbar radiculitis, lumbar spondylosis and lumbago. EMG/NCS studies were requested to rule out radiculopathy versus peripheral neuropathy because the patient has new symptoms of radiating pain down into the left leg with worsening numbness and tingling in the feet. Physical therapy for the lumbar spine was also requested. Treatment to date has included oral analgesics, muscle relaxants, home exercises and lumbar spine surgeries.

IMR ISSUES, DECISIONS AND RATIONALES

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

ELECTROMYOGRAPHY BILATERAL LOWER EXTREMITIES: Upheld

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

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

Decision rationale: According to page 303 of the ACOEM Low Back Guidelines as referenced by CA MTUS, electromyography (EMG) of the lower extremities is indicated to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than three to four weeks. Moreover, guidelines do not recommend EMG before conservative treatment. In this case, the patient has signs and symptoms consistent with lumbar radiculopathy. However, there was no documentation of the patient's response to conservative treatment such as home exercises; and it was unclear whether the patient had tried and exhausted other conventional treatments considering the duration of his injury. The medical necessity has not been established because the guideline criterion was not met. Therefore, the request for ELECTROMYOGRAPHY BILATERAL LOWER EXTREMITIES is not medically necessary.

NERVE CONDUCTION STUDIES BILATERAL LOWER EXTREMITIES: Upheld

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

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, NERVE CONDUCTION STUDIES

Decision rationale: The CA MTUS does not specifically address nerve conduction studies (NCS). Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines (ODG) was used instead. According to ODG, NCS of the lower extremities are not recommended if radiculopathy has already been clearly identified by EMG and obvious clinical signs. In this case, the patient presented with symptoms of radiculopathy supported by objective findings of neurologic deficits on physical examination. The guideline does not recommend NCV when radiculopathy is clinically evident. The medical necessity has not been established. Therefore, the request for NERVE CONDUCTION STUDIES BILATERAL LOWER EXTREMITIES is not medically necessary.

PHYSICAL THERAPY 2-3 X 4-6 FOR LUMBAR SPINE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES., ,

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHRONIC PAIN MEDICAL TREATMENT GUIDELINES 9792.24.2 Page(s): 98-99. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) LOW BACK CHAPTER, PHYSICAL THERAPY

Decision rationale: Page 98-99 of the CA MTUS Chronic Pain Medical Treatment Guidelines state that a time-limited treatment plan with clearly defined functional goals, frequent assessment and modification based upon the patient's progress in meeting those goals is paramount. Active therapy is recommended for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. ODG recommends a total of 10-12 visits over 8 weeks for thoracic/lumbosacral neuritis/radiculitis with a six-visit clinical trial. In this case, the patient complains of worsening bilateral low back pain and numbness and tingling in the bilateral lower extremities for which physical therapy for the lumbar spine was requested. However, there were no clearly defined functional goals for the treatment. Moreover, the requested number of visits exceeded the guideline recommendation. The guideline recommends a six-visit clinical trial with documentation of objective and measurable functional gains prior to continuation of treatment. In addition, there was no documentation of previous physical therapy sessions and the patient's response to the treatment, considering the duration of the injury. The guideline criteria were not met. Therefore, the request for PHYSICAL THERAPY 2-3 X 4-6 FOR LUMBAR SPINE is not medically necessary.