

Case Number:	CM14-0018593		
Date Assigned:	04/18/2014	Date of Injury:	07/21/2013
Decision Date:	07/02/2014	UR Denial Date:	01/15/2014
Priority:	Standard	Application Received:	02/13/2014

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 Occupational 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 38 year old male who was injured on 07/21/2013. He was washing the floor of a restaurant and as he was carrying a five-gallon bucket of soapy water he stepped on the cap of a bottle causing him to slip and fall. He landed in a seated position while holding the bucket causing the onset of pain in his left shoulder, upper and lower back/tailbone. Prior treatment history has included medication (Naproxen 550 mg, Cyclobenzaprine 7.5 mg, and Omeprazole 20 mg) and 5 sessions of physical therapy. Diagnostic studies reviewed include MRI of the lumbar spine dated 11/21/2013 revealing a 1-2 mm disc bulge at L5-S1 without evidence of canal stenosis or neural foraminal narrowing. PR-2 dated 09/16/2013 documented the patient with complaints of continuous upper/low back and tailbone pain with pain radiating into the left lower extremity. The pain is accompanied with numbness, weakness, tingling and burning sensation. His pain increases with prolonged standing, twisting, walking, lifting, bending, stooping and squatting. The patient rates the low back pain level as 8 on a scale of 1 to 10. Objective findings on examination of the lumbar spine reveals there is tenderness bilaterally over the paraspinal, quadrates lumborum and coccyx. Range of motion: flexion 40 degrees, extension 20 degrees. Straight leg raise on the right positive at 50 degrees and on the left positive at 30 degrees. Diagnoses: 1. Lumbar spine sprain/strain. 2. Coccygeal pain. Treatment Plan: Start physical therapy two times a week for four weeks and prescribed bracing of the lumbar spine. PR-2 dated 11/19/2013 authorization requested for EMG/NCV and physical therapy 2 times a week for four weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY ON THE LUMBAR 2 X 4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE Page(s): 98-99.

Decision rationale: The progress report dated 09/16/2013 indicates that patient had 5 sessions of physical therapy but continues to have lower back pain 8/10 on VAS scale. There is no evidence of objective functional improvement with the prior physical therapy completed. The patient was diagnosed with lumbar sprain/strain and coccygeal pain and the request exceeds the total allowed number of sessions as per the guidelines. Hence, the request for continued physical therapy 2 x4 weeks (8 sessions) is not medically necessary.

EMG ON LOWER EXTREMITIES: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Official Disability Guidelines (ODG) EMG Lower Extremity Guidelines.

Decision rationale: Nerve conduction study in lower back guidelines for ODG: "Not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. (Utah, 2006) This systematic review and meta-analysis demonstrate that neurological testing procedures have limited overall diagnostic accuracy in detecting disc herniation with suspected radiculopathy. (Al Nezari, 2013) In the management of spine trauma with radicular symptoms, EMG/nerve conduction studies (NCS) often have low combined sensitivity and specificity in confirming root injury, and there is limited evidence to support the use of often uncomfortable and costly EMG/NCS. (Charles, 2013) See also the Carpal Tunnel Syndrome Chapter for more details on NCS. Studies have not shown portable nerve conduction devices to be effective. EMGs (electromyography) are recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious." Therefore, this is not medically necessary per the documentation that was sent to me.

NERVE CONDUCTION BILATERAL ON LOWER EXTREMITIES: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Official Disability Guidelines (ODG) Nerve Conduction Study in Lower Back.

Decision rationale: Recommended as an option (needle, not surface). EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. (Bigos, 1999) (Ortiz-Corredor, 2003) (Haig, 2005) No correlation was found between intraoperative EMG findings and immediate postoperative pain, but intraoperative spinal cord monitoring is becoming more common and there may be benefit in surgery with major corrective anatomic intervention like fracture or scoliosis or fusion where there is significant stenosis. (Dimopoulos, 2004) EMG's may be required by the AMA Guides for an impairment rating of radiculopathy. (AMA, 2001). I am uncertain if this patient has had the recommended course of conservative treatment. Without this documentation this is not medically necessary.