

<b>Case Number:</b>	CM14-0019245		
<b>Date Assigned:</b>	06/11/2014	<b>Date of Injury:</b>	03/30/2013
<b>Decision Date:</b>	07/23/2014	<b>UR Denial Date:</b>	01/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/14/2014

### 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 and 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 24-year-old female with a reported date of injury on 03/30/2013. The injury reportedly occurred when the worker was restocking merchandise. The injured worker presented with lumbar spine pain, thoracic spine, bilateral shoulders, bilateral knees, right ankle and foot, and cervical spine pain. Upon physical examination, the injured worker's cervical spine range of motion revealed flexion to 40 degrees, extension to 30 degrees, left bending to 25 degrees, right bending to 20 degrees, and bilateral rotation to 60 degrees. In addition, the injured worker presented with positive axial compression, distraction test, and shoulder depression test. The injured worker's lumbar spine range of motion revealed flexion to 60 degrees, extension to 11 degrees, left bending to 25 degrees, right bending to 22 degrees, and bilateral rotation to 15 degrees. In addition, the injured worker presented with positive Kemp's test, straight leg test, Braggard's test, and Yeoman's test. The lumbar MRI dated 07/23/2013 revealed disc protrusion at the L4-5 level associated with mild compression of the right L5 nerve root and significant thecal sac compression. The physician indicated the injured worker had NCV/EMG studies on 01/27/2014, the results of which were not available for review. According to the clinical documentation provided for review, the injured worker completed 6 sessions of physical therapy, the results of which were not provided within the documentation available. In addition, the injured worker received 6 sessions of acupuncture. The injured worker's diagnoses included lumbar disc displacement, sciatica, cervical disc herniation, tear of the medial meniscus of the bilateral knees, chondromalacia patella of the bilateral knees, rotator cuff syndrome of the bilateral shoulders, tendonitis, bursitis, capsulitis of the right foot, plantar fasciitis of the right foot, depression, anxiety, and insomnia. The injured worker's medication regimen was not provided within the clinical documentation available for review. The Request for Authorization for physical therapy x 12 visits to the lumbar spine, lumbar support orthosis, and multi-

interferential stimulator x 30 days for the lumbar spine, Functional Capacity Evaluation, EMG on the bilateral lower extremities, and nerve conduction myography to the bilateral lower extremities was submitted on 02/14/2014. The physician indicated that physical therapy was requested to increase the injured worker's activities of daily living, decrease the work restriction, decrease the need for medication, and decrease the visual analog scale rating, decrease swelling, and increase active range of motion. In addition, the physician noted that the multi-interferential stimulator 1 month rental was prescribed to the injured worker in order to decrease pain and muscle spasm. The lumbosacral orthosis was prescribed for the injured worker to stabilize the lumbar spine and promote healing. In addition, the NCV/EMG testing of the bilateral lower extremities, the injured worker requires to evaluate nerve impingement based on the history of a herniated disc.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **PHYSICAL THERAPY X 12 VISITS TO THE LUMBAR SPINE: 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 Physical Medicine Page(s): 98.

**Decision rationale:** The California MTUS Guidelines state that physical medicine is recommended. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Injured workers are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. The guidelines recommend 8 to 10 visits over 4 weeks. The physician indicated that the goal of the sessions of physical therapy is to increase activities of daily living, decrease the work restrictions, decrease the need for medication, decrease the Visual Analog Scale rating, decrease swelling, and increase measured active range of motion. The documentation provided for review lacks the Visual Analog Scale rating and the injured worker's medication regimen. Within the documentation dated 12/23/2013, the physician indicated that the injured worker's restrictions for activities of daily living included she was not able to lift any heavy items. The clinical information provided for review lacks documentation of work restrictions. In addition, the clinical information indicates the injured worker has completed 6 sessions of physical therapy. There is a lack of documentation related to the outcome of physical therapy. In addition, the guidelines recommend 8 to 10 visits. The request for 12 additional visits exceeds the recommended guidelines. Therefore, the request for physical therapy x 12 sessions to the lumbar spine is non-certified.

#### **LUMBAR SUPPORT ORTHOSIS: 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): 300.

**Decision rationale:** The California ACOEM Guidelines state that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. According to the clinical information submitted for review, the physician indicated that lumbosacral orthosis was prescribed for the injured worker in order to stabilize the lumbar spine. There is a lack of documentation related to the lumbosacral instability. In addition, the guidelines state that lumbosacral orthosis is recommended only in the acute phases of injury. The injury occurred on 03/30/2013; therefore, the injured worker is outside the range of acute phase. In addition, the request as submitted failed to provide the frequency and directions for use of the lumbar support. Therefore, the request for lumbar support orthosis is non-certified.

**MULTI-INTERFERENTIAL STIMULATOR X 30 DAYS RENTAL FOR THE LUMBAR SPINE:** 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 Transcutaneous Electrotherapy Page(s): 114, 188.

**Decision rationale:** The California MTUS Guidelines state that transcutaneous electrotherapy represents a therapeutic use of electricity and is a modality that can be used in the treatment of pain. In addition, the guidelines state that interferential current stimulation is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise, and medications, there is limited evidence of improvement on these recommended treatments alone. The clinical information provided for review lacks documentation of the injured worker's home exercise, medication regimen, or the outcomes of previous physical therapy. In addition, the physician indicates that the multi-interferential stimulator 1 month rental was prescribed for the injured worker in order to decrease pain and muscle spasms. The clinical information provided lacks documentation of the injured worker's rated pain and complaints of muscle spasms. In addition, the request as submitted failed to provide the frequency and duration for the use of the multi-interferential stimulator. Therefore, the request for a multi-interferential stimulator x 30 days rental for the lumbar spine is non-certified.

**FUNCTIONAL CAPACITY EVALUATION:** 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 Functional Improvement Measures Page(s): 48.

**Decision rationale:** The California MTUS Guidelines state that functional improvement measures are recommended. The importance of an assessment is to have a measure that can be used repeatedly over the course of treatment to demonstrate improvement of function or maintenance of function that would otherwise deteriorate. It should include the following categories: functions and/or activities of daily living, self-report of disability. Physical impairments include objective measures of clinical exams; range of motion should be documented in degrees. Within the clinical information provided, the physician indicates that functional improvement measured through functional capacity exam is used as an assessment of measures that can be used repeatedly over the course of treatment. According to the clinical note dated 12/23/2013, the physician indicated the injured worker's activities of daily living deficits included being unable to lift heavy objects. The clinical information provided for review, lacks documentation of the injured worker's functional deficits. There is lack of documentation related to the injured worker's work restrictions and/or goals for returning to work. In addition, the request as it is submitted failed to provide the goals for the Functional Capacity Evaluation. Therefore, the request for Functional Capacity Evaluation is non-certified.

**EMG ON THE 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): 303-305.

**Decision rationale:** According to the California ACOEM Guidelines, electromyography may be useful to identify subtle neurological dysfunction in injured workers with low back symptoms lasting more than 3 or 4 weeks. The physician indicated that the injured worker required an NCV/EMG to evaluate nerve impingement based on history of herniated disc. The MRI of the lumbar spine dated 07/23/2013 revealed mild levoscoliosis demonstrated within the lumbar spine. The vertebrae are intact without fracture or destructive lesion. In addition, it was noted that this protrusion at the L4-5 level is associated with mild compression of the right L5 nerve root and significant thecal sac compression centrally and to the right. The neural foramen were reduced to the lower limits of normal in size at this level. In addition, the clinical information provided for review lacks documentation of neuropathic pain. There is a lack of documentation related to the injured worker's rated pain or functional deficits. In addition, it was noted that the myotomes were within normal limits bilaterally. The physician indicated that an EMG/NCV was completed on 01/27/2014, the results of which were not provided in the documentation available for review. The request is unclear as to whether this was a request for a second NCV/EMG or a prospective request for the EMG on 01/27/2013. Therefore, the request for EMG on the bilateral lower extremities is non-certified.

**NERVE CONDUCTION MYOGRAPHY TO THE 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, Nerve Conduction Studies (NCS).

**Decision rationale:** According to the Official Disability Guidelines, nerve conduction studies are not recommended. There is minimal justification for performing nerve conduction studies when an injured worker is presumed to have symptoms on the basis of radiculopathy. EMG/nerve conduction studies often have low combined sensitivities with the specificity in confirming root injury, and there is limited evidence to support the use of an uncomfortable and costly EMG/NCS. According to the clinical note dated 12/23/2013, the injured worker had limited lumbar range of motion. In addition, the injured worker presented with positive Kemp's test, straight leg test, Braggard's, and Yeoman's test. The guidelines state there is minimal justification for performing nerve conduction studies when an injured worker is presumed to have symptoms on the basis of radiculopathy. In addition, the guidelines do not recommend nerve conduction studies. Therefore, the request for nerve conduction myography to the bilateral lower extremities is non-certified.