

Case Number:	CM14-0169704		
Date Assigned:	10/23/2014	Date of Injury:	02/25/2011
Decision Date:	11/21/2014	UR Denial Date:	09/24/2014
Priority:	Standard	Application Received:	10/14/2014

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 Pain Management 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 injured worker is a 66 year old male with a date of injury on 2/25/2011. He is diagnosed with (a) cervical disc syndrome, (b) cervical spine spondylosis, (c) lumbar disc syndrome, (d) lumbar spinal stenosis, (e) retrolisthesis of L3-L4, (f) anterolisthesis of L4 on L5, and (g) bilateral rotator cuff syndrome. Prior treatments include right shoulder arthroscopy with repair, medications including Norco 10/325 mg #80, Lidoderm patches, cortisone injections, and physical therapy. A computed tomography (CT) scan of right shoulder report dated 7/15/2014 demonstrated mild acromioclavicular joint degenerative changes and mild degenerative changes of the bony glenoid. A computed tomography (CT)-scan of the lumbar spine without contrast revealed (a) bilateral sacroiliac joint degenerative changes, (b) mild scoliosis of the lumbar spine, (c) L1-2: there are mild-to-moderate disc space narrowing. There is broad-based anterior spur. There is broad-based posterior disc osteophyte complex, measuring a maximal of 3-mm in anterior/posterior (AP) diameter. This is indenting the anterior local sac with moderate spinal stenosis. There is mild left and moderate right neural foraminal narrowing. (d) L2-3: there are mild bilateral facet degenerative changes and ligamentum flavum hypertrophy. There is broad-based anterior spur. There is 2-3 mm broad-based posterior disc osteophyte complex. There is moderate spinal stenosis. There is mild left lateral recess and left neural foraminal narrowing. There is no right neural foraminal narrowing. (e) L3-4: there are mild to moderate bilateral facet degenerative changes and ligamentum flavum hypertrophy. There is severe disc space narrowing. There are moderate degenerative endplate changes. There is broad-based anterior spur. There is minimal retrolisthesis of L3 over L4. There is broad-based central, right paracentral and right neural foraminal disc osteophyte complex, measuring a maximal of 5-mm in anterior/posterior (AP) diameter. There is moderate to severe spinal stenosis. There is mild left lateral recess narrowing. There is moderate right lateral recess and right neural foraminal and

right neural foraminal narrowing. (f) L4-5: there are severe bilateral facet degenerative changes with Grade 1 anterolisthesis of L4 over L5. There is small-broad based anterior spur. There is 2-3 mm broad-based posterior disc bulge. There is severe spinal stenosis. There is moderate left and severe right neural foraminal narrowing. (g) L5-S1: there are moderate to severe bilateral facet degenerative changes. There is 2-mm broad-based posterior disc bulge. There is vacuum disc phenomenon. There is small broad-based anterior spur. There is no disc protrusion or extrusion or spinal stenosis. There are bilateral neural foraminal spurs with mild bilateral neural foraminal narrowing. A computed tomography (CT) scan of the cervical spine demonstrated (a) C2-3: there is mild to moderate disc space narrowing. There is small anterior spur. The pedicles are congenitally short. There is a 1-2 mm central disc protrusion. There is mild to moderate spinal stenosis. There is no right neural foraminal narrowing. There is mild left neural foraminal narrowing. (b) C3-4: there are postsurgical changes related to prior anterior cervical fusion and anterior fusion plates and screws in place with no evidence of failure of the hardware. There is solid fusion identified at this level. There is broad-based posterior spur, indenting the anterior cord. There are mild bilateral facet degenerative changes. There is moderate to severe narrowing of the spinal canal. There is moderate to severe bilateral neural foraminal narrowing. (c) C4-5: there are moderate to severe left and moderate right facet degenerative changes with Grade 1 anterolisthesis of C4 over C5. There is mild disc space narrowing. There is 1-2 broad-based posterior disc bulge. The pedicles are congenitally short. There is moderate spinal stenosis. There is severe left and moderate right neural foraminal narrowing. (d) C5-6: there is large anterior spur. There is severe disc space narrowing. There are moderate degenerative endplate changes. There is a 2-mm broad-based disc osteophyte complex, indenting the anterior cord. There is moderate to severe spinal stenosis. There is severe right and moderate to severe left neural foraminal narrowing. (e) C6-7: there is severe disc space narrowing. There are moderate degenerative endplate changes. There is broad-based anterior spur. There is vacuum disc phenomenon. There is 2-mm broad-based disc osteophyte complex, extending to bilateral neural foramina. The pedicles are congenitally short with moderate spinal stenosis. There is severe bilateral neural foraminal narrowing. and (f) C7-T1: there is moderate disc space narrowing. There is broad-based anterior spur. There is vacuum disc phenomenon. There are mild to moderate bilateral facet degenerative changes. There is minimal anterolisthesis of C7 over T1. There is 2-3 mm broad-based disc osteophyte complex indenting the anterior cord. There is moderate spinal stenosis. There is moderate to severe bilateral neural foraminal narrowing. Most recent records available for review dated 7/28/2014 noted that the injured worker complained of ongoing neck and low back pain with numbness along the bilateral upper and lower extremities. He related that he felt numbness shooting over the entire body and rated his pain as 8/10. He also stated that there was no change with therapy. He also continued to report difficulty with gait. He reported difficulty getting in and out of the bed and he reported cramping of the bilateral lower extremities. He also reported that he underwent cortisone injections since his last visit which provided 25% relief. He had a total of six injections to the shoulder. Objectively, he was noted with gait difficulty. He ambulated in a wheeled walker and was apprehensive with range of motion. Cervical spine examination noted tenderness over the paracervical muscles bilaterally. Range of motion was limited in all planes by pain. Foraminal compression test and shoulder depression test were positive, bilaterally. Lumbar spine examination noted tenderness over the paralumbar muscles bilaterally. Range of motion was limited in all planes with pain. Pain was noted to radiate along the bilateral lower extremities with flexion and extension. Shoulder examination noted limited range of motion bilaterally. Pain was noted over the abduction and internal and external rotation bilaterally. Impingement test was positive bilaterally. Upper motor strength was 4+/5 bilaterally. Hypersensitivity was noted along the C5-T1 dermatome distribution on the left. Lower extremity deep tendon reflexes was 3+, 2+, and 1+/4 bilaterally. Lower extremity motor exam was 4+/5, bilaterally. Hypersensitivity was noted

along the L3 through S1 dermatome distribution on the left.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home health care 2 to 3 hours per day, seven days a week, for 4 weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medicare Benefits Manual (Rev.144, 05-06-11), Chapter 7-Home Health Services; Section 50.2 (Home Health Aide Services)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services Page(s): 51.

Decision rationale: Evidence-based guidelines point out that home health care is recommended as a medical treatment for those who are home bound, on a part-time or "intermittent" basis, and generally up to no more than 35 hours per week. In this case, review of this injured worker's record do not indicate that the he is home bound as he can attend physical therapy sessions through the assistance of a walking aid and can performed independent home exercise program. Hence, the medical necessity of the requested home health care two to three hours per day, seven days a week for four weeks is not established. Therefore, the request is not medically necessary.

Functional capacity evaluation, QTY: 1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Fitness for Duty

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness For Duty Chapter, Functional Capacity Evaluation (FCE)

Decision rationale: According to evidence-based guidelines, a functional capacity evaluation (FCE) is recommended prior to admission to a work hardening program. Guidelines have set the following criteria to be warranted to proceed with a functional capacity evaluation (FCE): (A) case management is hampered by complex issues such as (1) prior unsuccessful return to work (RTW) attempts, (2) conflicting medical reporting on precautions and/in fitness for modified job, (3) injuries that require detailed exploration of a worker's abilities. (B) timing is appropriate: (1) close or at maximal medical improvement (MMI)/key medical reports secured and (2) additional/secondary conditions clarified. Guidelines indicate not to proceed with a functional capacity evaluation (FCE) if: (a) the sole purpose is to determine a worker's effort or compliance and (b) the worker returned to work and an ergonomic assessment has been arranged. However, guidelines indicate that little is known about the reliability and validity of these tests and more research is needed. In this case, the injured worker does not meet the above presented criteria. The injured worker is noted not to be close or at maximum medical improvement (MMI) as well. Also, the injured worker is already 66 years old which is past the retirement age. There is also no indication that the injured worker would like to go back to work or has ever tried to attempt to go back to work. Based on these reasons, the requested functional capacity evaluation is not established. Therefore, the request is not medically necessary.

EMG (Electromyography)/ NCS (Nerve Conduction Study) of the bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) : Neck and Upper Back (Acute and Chronic), Electromyography

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Electrodiagnostic testing (EMG/NCS)

Decision rationale: Evidence-based guidelines indicate that an electromyography (EMG)/nerve conduction velocity (NCV) tests may be performed in order to localize the source of neurological symptoms and establishing the diagnosis of a focal nerve entrapment including carpal tunnel syndrome or radiculopathy. Guidelines also indicate that electromyography (EMG) and nerve conduction studies (NCS) are separate studies and should not necessarily be done together.

Guidelines further state electromyography (EMG) is recommended as an option after a month of conservative therapy but this not necessary if radiculopathy is already clinically obvious. In this case, the documented subjective and physical examination findings as well as diagnostic imaging results already confirms radiculopathy in the upper extremities. Therefore, there is no need to perform an electromyography (EMG)/nerve conduction studies (NCS) thus the medical necessity of the requested electromyography (EMG)/nerve conduction studies (NCS) of the bilateral upper extremities is not established. Therefore, the request is not medically necessary.

EMG (Electromyography)/ NCS (Nerve Conduction Study): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) : Low Back-Lumbar and Thoracic (Acute and Chronic),

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Electrodiagnostic testing (EMG/NCS)

Decision rationale: Evidence-based guidelines indicate that an electromyography (EMG)/nerve conduction velocity (NCV) may be performed in order to localize the source of neurological symptoms and establishing the diagnosis of a focal nerve entrapment including carpal tunnel syndrome or radiculopathy. Guidelines also indicate that electromyography (EMG) and nerve conduction studies (NCS) are separate studies and should not necessarily be done together. Guidelines further state that electromyography (EMG) is recommended as an option after a month of conservative therapy but this not necessary if radiculopathy is already clinically obvious. Review of this injured worker's records already pinpoints that radiculopathy are apparent due to the presence sensory and motor deficits which is further corroborated by positive diagnostic imaging studies. Moreover, nerve conduction studies (NCS) are not recommended in the lumbar spine. Hence, the medical necessity of the requested electromyography (EMG)/nerve conduction velocity (NCV) of the bilateral lower extremities is not established. Therefore, the request is not medically necessary.