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| Case Number: | CM14-0184607 | | |
| Date Assigned: | 11/12/2014 | Date of Injury: | 03/31/2014 |
| Decision Date: | 12/15/2014 | UR Denial Date: | 10/30/2014 |
| Priority: | Standard | Application Received: | 11/05/2014 |

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 Arizona and 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 25-year-old male who reported an injury on 03/31/2014. While the injured worker was working as a delivery man for a mattress company; he had unloaded a new mattress, was taking the old mattress; when he went to go pull the plastic, the mattress came with it, feeling a sharp pain to his back. The injured worker complained of lower back pain that he described as sharp and aching. The injured worker was not taking any medication for pain. However, he rated his pain an 8/10 using the VAS. Prior treatments included 26 sessions of chiropractic therapy and 15 sessions of physical therapy and modified duties. The unofficial MRI of the lumbar spine dated 07/11/2014 revealed degenerative changes of the lumbar spine secondary to multilevel disc bulge; facet and ligamentum flavum hypertrophy was noted at the L4-5 secondary to a large disc protrusion. The x-ray of the lumbar spine of unknown date revealed loss of lordosis and a herniated lumbar disc at the L4-5, L5-S1, and L3-4 with radiculitis/radiculopathy, left greater than right. The physical examination dated 09/03/2014 of the lumbar spine revealed range of motion with flexion at 70 degrees and extension at 20 degrees, with decreased lordosis. Lasegue's was positive bilaterally. Positive straight leg raise at 70 degrees to the left and cross positive 85 degrees on the right, eliciting pain at the L5-S1 dermatome distribution. Upon palpation, tightness and spasms at the paraspinal musculature. Hypo paresthesia at the anterolateral aspect of the foot and ankle of an incomplete nature noted at the L5 and S1 dermatome level bilaterally. Facet joint tenderness at the L5 level bilaterally. Treatment plan included additional physical therapy 2 x6 to the lumbar spine. The Request for Authorization dated 11/12/2014 was submitted with documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2 x 6 to lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines, Physical Therapy Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

Decision rationale: The request for physical therapy 2 x 6 to lumbar spine is not medically necessary. The California MTUS state that 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. Active therapy requires an internal effort by the individual to complete a specific exercise or task. 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 indicate that for Neuralgia, neuritis, and radiculitis, unspecified the recommended visits for physical therapy are 8-10 visits over 4 weeks. The injured worker has received 15 visits of physical therapy along with 26 visits of chiropractic therapy. The guidelines indicate 8 to 10 visits, and the request is for an additional 12 visits, which exceeds the recommended guidelines. The documentation did not indicate any special circumstances to warrant additional physical therapy. As such, the request is not medically necessary.

EMG/NCV to bilateral lower extremities: 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 Chapter, EMG

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, NCV

Decision rationale: The request for EMG/NCS to the bilateral lower extremities is not medically necessary. The California MTUS/ACOEM Guidelines state that electromyography may be useful to identify subtle, focal neurologic dysfunction in injured workers with low back symptoms lasting more than 3 or 4 weeks. There was a lack of neurological deficits pertaining to the lumbar spine documented. There is no indication of failure of conservative care treatment to include medication management. As such, the request is not medically necessary. The Official Disability guidelines state that NCV is not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. There is a lack of documentation indicating positive provocative testing indicating pathology to the lumbar that revealed lack of functional deficits. The clinical note revealed low back pain with radiation to lower bilateral extremities. However, there is no

evidence of reflex deficits. There is no indication of failure of conservative care treatment to include medication management. Furthermore, the guidelines do not recommend NCV for lower extremity. As such, the request is not medically necessary.

DME rental: IF unit x 60 days: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS).

Decision rationale: The request for IF unit x 60 days is not medically necessary. The California MTUS does 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, and limited evidence of improvement on those recommended treatments alone. Per the guidelines, the use of the IF unit is not recommended for isolated use. Additionally, the request did not indicate the body part the unit was intended for. As such, the request is not medically necessary and appropriate.