

Case Number:	CM13-0029104		
Date Assigned:	01/15/2014	Date of Injury:	11/01/1999
Decision Date:	04/02/2015	UR Denial Date:	09/05/2013
Priority:	Standard	Application Received:	09/26/2013

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 55 year old male injured worker suffered and industrial injury on 11/1/1999. The diagnoses were lumbosacral spondylosis, lumbar stenosis, and lumbar disc herniation with increasing radiculopathy. The diagnostic studies were magnetic resonance imaging and x-rays. The treatments were medications, physical therapy, and epidural steroid injections. The treating provider reported stabbing pain, left sided low back pain radiating to the left leg with numbness and aching along with leg weakness. There was tenderness over the left sciatic notch with spasms, and diminished sensation in the sciatic distribution. Range of motion was limited. The provider stated the condition was severe with increasing neurological deficits. The pain was rated as 9/10. The Utilization Review Determination on 9/5/2013 non-certified: 1. 1 lumbar spine, selective nerve root block, levels L5-S1, citing MTUS. 2. 12 physical therapy for the lumbar spine, citing MTUS,ACOEM. 3. 1 MRI scan of the lumbar spine, citing MTUS,ACOEM. 4. 1 electromyography and nerve conduction velocity studies of the left lower extremity, citing MTUS, ACOEM.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 LUMBAR SPINE, SELECTIVE NERVE ROOT BLOCK, LEVELS L5-S1 AS AN OUTPATIENT: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ESI Page(s): 46-47.

Decision rationale: According to the 07/30/2013 report, this patient presents with "chronic radiating low back pain." The current request is for Lumbar spine, selective nerve root block, level L5-S1 as an outpatient. The request for authorization is on 07/30/2014. The patient's work status was not mentioned in the provided report. Regarding ESI, MTUS guidelines states "radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing." For repeat injections, MTUS requires "continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year." Review of the provided report does not mention prior epidural steroid injections. In this case, the treating physician documented that the patient has diminished sensation in the S1 distribution and there is positive Lasegue's test. However, the treating physician does not discuss or provide MRI findings or other studies that would corroborate the patient's symptoms. Without an imaging study or electrodiagnostic study to corroborate radiculopathy the MTUS guideline recommendations cannot be followed. The request IS NOT medically necessary.

12 PHYSICAL THERAPY FOR THE LUMBAR SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

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

Decision rationale: According to the 07/30/2013 report, this patient presents with "chronic radiating low back pain." The current request is for 12 physical therapy for the lumbar spine. The Utilization Review denial letter states "the claimant has had extensive physical therapy. In the past she had been doing home exercise on a regular basis." For physical medicine, MTUS guidelines pages 98, 99 state that for myalgia and myositis, 9-10 visits are recommended over 8 weeks. For neuralgia, neuritis, and radiculitis, 8-10 visits are recommended. Review of available records show no therapy reports and there is no discussion regarding the patient's progress. There is no documentation of flare-up or a new injury to warrant formalized therapy. The treater does not discuss the patient's treatment history nor the reasons for requested additional therapy. No discussion is provided as to why the patient is not able to continue the home exercises. MTUS page 8 requires that the treater provide monitoring of the patient's progress and make appropriate recommendations. In addition, the requested 12 sessions exceed what is allowed by MTUS guidelines. MTUS supports 8-10 sessions of physical therapy for this type of myalgia condition. The current request IS NOT medically necessary.

1 MRI SCAN OF THE LUMBAR SPINE AS AN OUTPATIENT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines low back chapter; Magnetic resonance imaging.

Decision rationale: According to the 07/30/2013 report, this patient presents with "chronic radiating low back pain." The current request is for 1 MRI of the lumbar spine as an outpatient. In reviewing the provided reports, the treating physician indicates that the patient had an MRI in 2001, symptoms are debilitating. However, the result of the MRI was not provided for review. Regarding repeat MRI study, ODG states "is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation)." In this case, the treating physician state that the patient's symptoms are debilitating, but did not document neurologic deterioration such as new weakness; no red flags such as bowel bladder symptoms; suspicion for tumor, infection, fracture; no significant change in examination; no new injury to warrant an updated MRI. The current request IS NOT medically necessary.

1 ELECTROMYOGRAPHY AND NERVE CONDUCTION VELOCITY STUDIES OF THE LEFT LOWER EXTREMITY: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official disability guidelines Low back chapter: Electrodiagnostic Studies.

Decision rationale: According to the 07/30/2013 report, this patient presents with "chronic radiating low back pain." The current request is for 1 electromyography and nerve conduction velocity studies of the left lower extremity. Regarding electrodiagnostic studies of lower extremities, ACOEM page 303 support EMG and H-reflex tests to determine subtle, focal Neurologic deficit. Review of the provided reports does not show any evidence of EMG being done in the past. In this case, the treating physician has requested for an EMG of the left lower extremities and the guidelines support this request it. The request IS medically necessary.