

Case Number:	CM14-0188252		
Date Assigned:	11/18/2014	Date of Injury:	03/31/2014
Decision Date:	01/15/2015	UR Denial Date:	10/30/2014
Priority:	Standard	Application Received:	11/12/2014

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:

This 25 year old male was a delivery man when he sustained an injury on March 31, 2013. The injured worker reported he was wrapping a mattress with plastic and had a sudden onset of lower back pain when he pulled on the plastic. Along with the plastic, the mattress was pulled. The injured worker later developed difficulty walking due to the pain. Initial treatment included x-rays, medications, chiropractic therapy, and activity modifications. The medical records refer to a prior course of 15 sessions of physical therapy. The medical records show reports of service of 2 sessions of physical therapy with electrical stimulation, hot/cold packs, vasopneumatic device, and massage from June 30, 2014 to July 14, 2014. On July 11, 2014, a MRI of the lumbar spine revealed a large central disc herniation of L4-5, without scoliosis or instability. On September 3, 2014, the primary treating physician noted intermittent, sharp, aching lower back pain with radiation down the left leg to the ankle. The pain was rated 8/10. The physical exam revealed mild to moderately decreased range of motion of the lumbar spine, decreased lordosis, positive left Lasegue's and unequivocal on the right, positive bilateral straight leg raise that produced pain in the L5-S1 dermatome distribution, normal knee and ankle reflexes, tightness and spasm of the paraspinal musculature, and no tenderness of the posterior/superior spine, sciatic notch, sciatic nerve area, and sacroiliac joints. There was mild weakness of both feet, and decreased lumbar spine sensation the levels of L4-S1 on the right side and L5-S1 on the left. Diagnoses included herniated lumbar disc L4-5, greater than L5-S1 and L3-4 with radiculitis/radiculopathy. The physician recommended a lumbar epidural steroid injection. Following the epidural steroid injection, the physician recommended a hot/cold contrast unit, IF unit, EMG/NCV to bilateral lower extremities, and physical therapy. The work status was temporarily totally disabled. On October 30, 2014 Utilization Review non-certified a prescription for 12 (twice a week for 6 weeks) visits of physical therapy to the lumbar spine, EMG/NCV (electromyography/ nerve

conduction velocity) to bilateral lower extremities, and rental of an IF (Inferential) unit x 60 days. The physical therapy was non-certified based on the lack of evidence of objective improvement from prior treatment, functional deficits, functional goals, and documentation of the reason why an independent home exercise program would be insufficient to address any remaining functional deficits. In addition, the proposed prescription of physical therapy exceeds the recommendations of the applicable guidelines, as the injured worker had already completed 14 visits. The California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines for physical medicine, the American College of Occupational and Environmental for physical therapy for the lower back, and the Official Disability Guidelines (ODG) for Physical Therapy were cited. The EMG/NCV was non-certified based on documentation of medical necessity for the EMG was not clear. The MRI revealed focal findings that corroborated the physical examination findings, and there was no evidence of peripheral neuropathy or entrapment confounding the clinical picture. The American College of Occupational and Environmental guidelines for Low Back Disorders (updated 4/7/08) and the Official Disability Guidelines (ODG) Low Back Chapter, EMGs electromyography were cited. The rental of an IF unit was non-certified based on lack of documentation to support that the applicable guidelines' criteria for the use of an IF unit were met. There was no documentation of ongoing conservative treatment or the objective findings that would meet the criteria. There was no documentation of an IF unit being used along with physical therapy or an ongoing program for functional restoration. There was no documentation of the ineffectiveness or side effects of medications, history of substance abuse, an inability to respond to conservative treatment or perform physical therapy, and an ongoing exercise program and functional restoration with demonstrated functional improvement. The California Medical Treatment Utilization Schedule (MTUS), Inferential Current Stimulation (ICS) and the Official Disability Guidelines (ODG) were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2x6 to lumbar spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Physical therapy. Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines support a brief course of physical medicine for patients with chronic pain not to exceed 10 visits over 4-8 weeks with allowance for fading of treatment frequency, with transition to an active self-directed program of independent home physical medicine/therapeutic exercise. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or

improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG recommends a limited course of physical therapy for patients with a diagnosis of lumbar radiculitis not to exceed 12 visits over 8 weeks. ODG also notes patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy) and when treatment requests exceeds guideline recommendations, the physician must provide a statement of exceptional factors to justify going outside of guideline parameters. Within the medical information available for review, there is documentation of a diagnosis of herniated lumbar disc L4-5 greater than L5-S1 and L3-4 with radiculitis/radiculopathy, left greater than right. In addition, there is documentation of previous physical therapy. However, given documentation of at least 15 sessions of physical therapy completed to date, which exceeds guidelines, there is no documentation of remaining functional deficits that would be considered exceptional factors to justify exceeding guidelines. In addition, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of physical therapy provided to date. Therefore, based on guidelines and a review of the evidence, the request for Physical therapy 2x6 to lumbar spine 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, 62. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, EMGs.

MAXIMUS 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, Electrodiagnostic studies

Decision rationale: MTUS reference to ACOEM guidelines identifies documentation of focal neurologic dysfunction in patients with low back symptoms lasting more than three to four weeks, as criteria necessary to support the medical necessity of electrodiagnostic studies. ODG identifies documentation of evidence of radiculopathy after 1-month of conservative therapy, as criteria necessary to support the medical necessity of electrodiagnostic studies. In addition, ODG does not consistently support performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Within the medical information available for review, there is documentation of a diagnosis of herniated lumbar disc L4-5 greater than L5-S1 and L3-4 with radiculitis/ radiculopathy, left greater than right. In addition, given documentation of subjective (ongoing moderate to severe low back pain radiating to the left leg and down to the ankle following the L5 and S1 dermatomal distributions) and objective (decreased ankle reflexes bilaterally, hypoesthesia at the anterolateral aspect of the feet and ankle at the L5 and S1 dermatomes bilaterally, and weakness in the big toe dorsiflexors and plantar flexors bilaterally) findings, there is documentation of focal neurologic dysfunction in patients with low back symptoms lasting more than three to four weeks, as criteria necessary to support the medical necessity of electrodiagnostic studies. ODG identifies documentation of evidence of radiculopathy. However, given documentation of an associated request for physical therapy to

the lumbar spine and IF unit, there is no documentation of failure of 1-month of conservative therapy. In addition, there is no documentation of a rationale for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Therefore, based on guidelines and a review of the evidence, the request for EMG/NCV to bilateral lower extremities is not medically necessary.

Rental: IF unit x 60 days: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that interferential current stimulation is not recommended as an isolated intervention and that 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. Within the medical information available for review, there is documentation of a diagnosis of herniated lumbar disc L4-5 greater than L5-S1 and L3-4 with radiculitis/radiculopathy, left greater than right. However, given documentation of an associated request for physical therapy and medications, there is no documentation that the IF unit will be used in conjunction with recommended treatments, including return to work and exercise, and limited evidence of improvement on those recommended treatments alone. Therefore, based on guidelines and a review of the evidence, the request for Rental: IF unit x 60 days is not medically necessary.