

Case Number:	CM15-0109995		
Date Assigned:	06/16/2015	Date of Injury:	02/25/2014
Decision Date:	09/22/2015	UR Denial Date:	05/22/2015
Priority:	Standard	Application Received:	06/08/2015

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 injured worker is a 35 year old male who sustained an industrial injury on 02/25/14. Initial complaints and diagnoses are not available. Treatments to date include a pain injection to the hip and medications. Diagnostic studies include x-rays of the thoracic and lumbar spines. Current complaints include pain in the low back and bilateral legs, as well as anxiety, depression, and insomnia. Current diagnoses include lumbar spine strain/sprain, rule out radiculitis/radiculopathy; and left hip strain/sprain, rule out internal derangement. In a progress note dated 04/13/15 the treating provider reports the plan of care as electrodiagnostic and nerve conduction studies of the bilateral lower extremities, MRIs of the lumbar spine and left hip, interferential unit, physiotherapy for the lumbar spine, and a lumbosacral orthotic brace. The requested treatments include electrodiagnostic and nerve conduction studies of the bilateral lower extremities, MRIs of the lumbar spine and left hip, interferential unit, physiotherapy for the lumbar spine, and a lumbosacral orthotic brace.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physiotherapy 2 times a week for 6 weeks to the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

Decision rationale: The patient presents on 04/13/15 with lumbar spine pain rated 8/10 which radiates into the left lower extremity, right leg pain rated 3/10 which radiates into the ankle. The patient's date of injury is 02/25/14. Patient has no documented surgical history directed at these complaints. The request is for PHYSIOTHERAPY 2 TIMES A WEEK FOR 6 WEEKS TO THE LUMBAR SPINE. The RFA is dated 04/13/15. Physical examination dated 04/13/15 reveals tenderness to palpation of the lumbar paraspinal musculature, decreased range of lumbar motion with positive straight leg raise noted bilaterally, eliciting pain in the L5-S1 dermatomal distribution. The provider also notes decreased sensation in the anteriolateral aspect of the bilateral feet and ankles consistent with the L5-S1 dermatomal distribution, and facet joint tenderness at L3 through L5 levels bilaterally. Left hip examination reveals positive Trendelenburg test, reduced range of motion in all planes, and tenderness over the trochanteric bursa. The patient is not currently prescribed any medications. Diagnostic imaging includes discussion of undated lumbar X-ray, showing: "severe narrowing L5-S1, loss of lordosis, limited range of motion." Patient is currently working. MTUS pages 98, 99 has the following: "Physical Medicine: recommended as indicated below. Allow for fading of treatment frequency -from up to 3 visits per week to 1 or less-, plus active self-directed home Physical Medicine." MTUS guidelines pages 98, 99 states that for "Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis, and radiculitis, 8-10 visits are recommended." In regard to the 12 physical therapy sessions for the lumbar spine, the provider has exceeded guideline recommendations. The documentation provided does not indicate that this patient has had any PT to date. MTUS allows for 8-10 sessions of physical therapy for complaints of this nature. Were the request for 10 sessions of physical therapy, the recommendation would be for approval; however the request as written exceeds guidelines and cannot be substantiated. Therefore, the request IS NOT medically necessary.

Electromyograph (EMG) and nerve conduction velocity (NCV) of the bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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 chapter under EMGs -electromyography Low Back chapter under Nerve conduction studies -NCS.

Decision rationale: The patient presents on 04/13/15 with lumbar spine pain rated 8/10 which radiates into the left lower extremity, right leg pain rated 3/10 which radiates into the ankle. The patient's date of injury is 02/25/14. Patient has no documented surgical history directed at these complaints. The request is for ELECTROMYOGRAPH (EMG) AND NERVE CONDUCTION VELOCITY (NCV) OF THE BILATERAL LOWER EXTREMITIES. The

RFA is dated 04/13/15. Physical examination dated 04/13/15 reveals tenderness to palpation of the lumbar paraspinal musculature, decreased range of lumbar motion with positive straight leg raise noted bilaterally, eliciting pain in the L5-S1 dermatomal distribution. The provider also notes decreased sensation in the anteriolateral aspect of the bilateral feet and ankles consistent with the L5-S1 dermatomal distribution, and facet joint tenderness at L3 through L5 levels bilaterally. Left hip examination reveals positive Trendelenburg test, reduced range of motion in all planes, and tenderness over the trochanteric bursa. The patient is not currently prescribed any medications. Diagnostic imaging includes discussion of undated lumbar X-ray, showing: "severe narrowing L5-S1, loss of lordosis, limited range of motion." Patient is currently working. ODG Low Back chapter under EMGs -electromyography- ODG states, Recommended as an option needle, not surface. EMGs may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. ODG, Low Back chapter under Nerve conduction studies -NCS- states, not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. ODG for Electrodiagnostic studies states, "NCS which are not recommended for low back conditions, and EMGs which are recommended as an option for low back." The medical records provided do not indicate that the patient has previously obtained electrodiagnostic studies of the lower extremities. The treating physician in this case has documented that the patient has lower back pain which radiates into the lower extremities with examination findings consistent with neurological dysfunction/nerve root compromise. Guidelines support EMG studies for patients presenting with radiculopathy in the lower extremities. Unfortunately, guidelines only support NCV studies of the lower extremities in circumstances where the provider suspects peripheral neuropathy or a neurological condition other than spinal stenosis. Were the request for an EMG study of the bilateral lower extremities, the recommendation would be for approval. However, the current request as written, is not supported by guidelines and is NOT medically necessary.

MRI of the lumbar spine: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back chapter under MRI.

Decision rationale: The patient presents on 04/13/15 with lumbar spine pain rated 8/10 which radiates into the left lower extremity, right leg pain rated 3/10 which radiates into the ankle. The patient's date of injury is 02/25/14. Patient has no documented surgical history directed at these complaints. The request is for MRI OF THE LUMBAR SPINE. The RFA is dated 04/13/15. Physical examination dated 04/13/15 reveals tenderness to palpation of the lumbar paraspinal musculature, decreased range of lumbar motion with positive straight leg raise noted bilaterally, eliciting pain in the L5-S1 dermatomal distribution. Left hip examination reveals positive Trendelenburg test, reduced range of motion in all planes, and tenderness over the trochanteric bursa. The provider also notes decreased sensation in the anteriolateral aspect of the bilateral feet

and ankles consistent with the L5-S1 dermatomal distribution, and facet joint tenderness at L3 through L5 levels bilaterally. The patient is not currently prescribed any medications. Diagnostic imaging includes discussion of undated lumbar X-ray, showing: "severe narrowing L5-S1, loss of lordosis, limited range of motion." Patient is currently working. For special diagnostics, ACOEM Guidelines page 303 states, "Unequivocal and equivocal objective findings that identify specific nerve compromise on neurological examination are sufficient evidence to warrant imaging in patients who do not respond well to treatment and who could consider surgery an option. Neurological examination is less clear; however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study." ODG Guidelines on low back chapter MRI topic states that MRIs are test of choice for patients with prior back surgery, but for uncomplicated low back pain with radiculopathy, not recommended until at least 1 month of conservative therapy, sooner if severe or progressive neurologic deficit. Repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology such as a tumor, infection, fracture, nerve compromise, recurrent disk herniation. In regard to the initial lumbar MRI directed at this patient's lower back pain, the request is appropriate. The progress report dated 04/13/15 includes documentation of lower back pain which radiates into the lower extremities, and examination findings suggestive of spinal stenosis/nerve root compromise. There is no evidence that this patient has had any MRI imaging of the lumbar spine performed to date. Such imaging could provide valuable insight into this patient's condition and improve the course of care. Therefore, the request IS medically necessary.

MRI of the left hip: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip and Pelvis Chapter, under MRI.

Decision rationale: The patient presents on 04/13/15 with lumbar spine pain rated 8/10 which radiates into the left lower extremity, right leg pain rated 3/10 which radiates into the ankle. The patient's date of injury is 02/25/14. Patient has no documented surgical history directed at these complaints. The request is for MRI OF LEFT HIP. The RFA is dated 04/13/15. Physical examination dated 04/13/15 reveals tenderness to palpation of the lumbar paraspinal musculature, decreased range of lumbar motion with positive straight leg raise noted bilaterally, eliciting pain in the L5-S1 dermatomal distribution. Left hip examination reveals positive Trendelenburg test, reduced range of motion in all planes, and tenderness over the trochanteric bursa. The provider also notes decreased sensation in the anteriolateral aspect of the bilateral feet and ankles consistent with the L5-S1 dermatomal distribution, and facet joint tenderness at L3 through L5 levels bilaterally. The patient is not currently prescribed any medications. Diagnostic imaging includes discussion of undated lumbar X-ray, showing: "severe narrowing L5-S1, loss of lordosis, limited range of motion." Patient is currently working. ODG Guidelines, Hip and Pelvis Chapter, under MRI states: Recommended as indicated below. MRI is the most accepted form of imaging for finding avascular necrosis of the hip and osteonecrosis. MRI is both highly

sensitive and specific for the detection of many abnormalities involving the hip or surrounding soft tissues and should, in general, be the first imaging technique employed following plain films. Indicators include osseous, articular, or soft tissue abnormalities; osteonecrosis; occult, acute, and stress fracture; acute and chronic soft tissue injuries; and tumors. In regard to the MRI of the left hip, the request is appropriate. Per RFA dated 04/13/15, treater's reason for the request is "left hip sprain/strain rule out internal derangement." There is no evidence in the records provided that this patient has undergone any MRI imaging of the left hip to date. Examination dated 04/13/15 includes documentation of decreased range of motion in the left hip, pain elicitation upon internal and external rotation, and tenderness over the trochanteric bursa. Given these examination findings suggestive of abnormalities in the joint, an initial MRI study is appropriate and could help identify the underlying pathology. The request IS medically necessary.

IF unit for home use and pain relief (use 30 minutes, 3 times a day for 60 days): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment guidelines under inferential current stimulation Page(s): 120.

Decision rationale: The patient presents on 04/13/15 with lumbar spine pain rated 8/10 which radiates into the left lower extremity, right leg pain rated 3/10 which radiates into the ankle. The patient's date of injury is 02/25/14. Patient has no documented surgical history directed at these complaints. The request is for IF UNIT FOR HOME USE AND PAIN RELIEF (USE 30 MINS, 3 TIMES A DAY FOR 60 DAYS). The RFA is dated 04/13/15. Physical examination dated 04/13/15 reveals tenderness to palpation of the lumbar paraspinal musculature, decreased range of lumbar motion with positive straight leg raise noted bilaterally, eliciting pain in the L5-S1 dermatomal distribution. Left hip examination reveals positive Trendelenburg test, reduced range of motion in all planes, and tenderness over the trochanteric bursa. The provider also notes decreased sensation in the anteriolateral aspect of the bilateral feet and ankles consistent with the L5-S1 dermatomal distribution, and facet joint tenderness at L3 through L5 levels bilaterally. The patient is not currently prescribed any medications. Diagnostic imaging includes discussion of undated lumbar X-ray, showing: "severe narrowing L5-S1, loss of lordosis, limited range of motion." Patient is currently working. Regarding interferential current stimulation, MTUS Chronic Pain Medical Treatment guidelines page 120 has the following: "Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: Pain is ineffectively controlled due to diminished effectiveness of medications; or Pain is ineffectively controlled with medications due to side effects; or History of substance abuse; or Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or Unresponsive to conservative measures (e.g., re-positioning, heat/ice, etc.). If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction." In regard to the 60 day rental of an IF unit for this patient's chronic pain, the provider has not

demonstrated IF unit efficacy. Progress notes provided do not indicate that this patient has trialed an IF unit to date, though the patient's failure to respond to conservative treatments is not clear as only one progress report was provided. MTUS guidelines support the purchase of an IF unit only if proven effective during a 30 day trial period. However, the requesting provider has specified a 60 day use period without first demonstrating efficacy of the unit. Were the request for a 30 day rental of the unit for trial, the recommendation would be for approval. However, without evidence of a successful trial, however, the request as written cannot be substantiated. The request IS NOT medically necessary.

LSO brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back chapter under lumbar supports.

Decision rationale: The patient presents on 04/13/15 with lumbar spine pain rated 8/10 which radiates into the left lower extremity, right leg pain rated 3/10 which radiates into the ankle. The patient's date of injury is 02/25/14. Patient has no documented surgical history directed at these complaints. The request is for LSO BRACE. The RFA is dated 04/13/15. Physical examination dated 04/13/15 reveals tenderness to palpation of the lumbar paraspinal musculature, decreased range of lumbar motion with positive straight leg raise noted bilaterally, eliciting pain in the L5-S1 dermatomal distribution. The provider also notes decreased sensation in the anteriolateral aspect of the bilateral feet and ankles consistent with the L5-S1 dermatomal distribution, and facet joint tenderness at L3 through L5 levels bilaterally. Left hip examination reveals positive Trendelenburg test, reduced range of motion in all planes, and tenderness over the trochanteric bursa. The patient is not currently prescribed any medications. Diagnostic imaging includes discussion of undated lumbar X-ray, showing: "severe narrowing L5-S1, loss of lordosis, limited range of motion." Patient is currently working. The ACOEM Guidelines page 301 on lumbar bracing states, "Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief." ODG Guidelines under the Low Back chapter on lumbar supports states, "Not recommended for prevention; however, recommended as an option for compression fracture and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific low back pain, very low quality evidence, but may be a conservative option." In regard to the request for a lumbar spine orthotic, the request is not supported by guidelines for nonspecific lumbar pain. Progress reports provided do not indicate that this patient has been issued any DME bracing for the lumbar spine to date. While ODG guidelines indicate that such bracing is a conservative option for nonspecific low back pain there is very low grade evidence for this treatment modality. This patient is an otherwise healthy 35 year old male with no history of surgical intervention in the lumbar spine. There is no evidence that this patient has any lumbar instability, fractures, or other acute injury which would warrant a lumbar brace. Therefore, the request IS NOT medically necessary.