

Case Number:	CM15-0013023		
Date Assigned:	02/06/2015	Date of Injury:	11/18/2014
Decision Date:	04/01/2015	UR Denial Date:	12/23/2014
Priority:	Standard	Application Received:	01/22/2015

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:

This 37-year-old male sustained a work-related back injury on 11/18/2014. According to the PR2 dated 12/3/2014, the injured worker's (IW) diagnoses are sprain of lumbosacral spine, muscle spasm and reported history of lumbar disc protrusion. He reports low back pain unchanged from the last visit. Previous treatments include medications and activity modification. The treating provider requests EMG/NCV testing of the bilateral lower extremities; purchase of a lumbosacral brace, purchase of an interferential unit and purchase of a hot and cold unit for the low back. The Utilization Review on 1/22/2015 non-certified EMG/NCV testing of the bilateral lower extremities; purchase of a lumbosacral brace, purchase of an interferential unit and purchase of a hot and cold unit for the low back, citing CA MTUS Chronic Pain Medical Treatment guidelines and ODG.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV Bilateral Lower Extremities: Upheld

Claims Administrator 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) Electrodiagnostic Studies (EDS), Electromyography (EMGs), Nerve Conduction Studies (NCS), Lumbar Supports.

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 on EMG and NCV.

Decision rationale: This patient presents with low back pain. The treater is requesting EMG/NCV BILATERAL LOWER EXTREMITIES. The RFA was not made available for review. The patient's stated injury is from 11/18/2014 and he is currently on modified duty. The ACOEM Guidelines page 303 states that electromyography EMG including H-reflex test may be useful to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks. In addition, ODG does not recommend NCV. There is minimal justification for performing nerve conduction studies when the patient is presumed to have symptoms on the basis of radiculopathy. The systemic review and meta-analysis demonstrated neurological testing procedures have limited overall diagnostic accuracy in detecting disk herniation with suspected radiculopathy. In the management of spine trauma with radicular symptoms, EMG/NCS often have low combined sensitivity and specificity in confirming root injury. The records do not show any previous EMG/NCV of the bilateral lower extremities. The 12/03/2014 report notes that the patient's condition is unchanged. He continues to have paravertebral lumbar spine pain. No other findings were noted on this report. In this case, the patient does not present with radiating symptoms to the bilateral lower extremities including neurological and sensory deficits that would warrant the need for an EMG/NCV of the lower extremities. The request IS NOT medically necessary.

Purchase of Lumbosacral Brace: 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), Electrodiagnostic Studies (EDS), (EMGs) Electromyography, Nerve Conduction Studies (NCS).

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

Decision rationale: This patient presents with low back pain. The treater is requesting PURCHASE OF LUMBOSACRAL BRACE. The RFA was not made available for review. The patient's stated injury is from 11/18/2014 and he is currently on modified duty. 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. The records do not show any previous request for a lumbosacral brace. The report making the request was not made available. The patient is not post-surgery. The 12/03/2014 show paravertebral lumbar spine pain. The examination does not

show any evidence of spondylolisthesis and instability. In this case, the patient does not meet the criteria set forth by the ODG Guidelines for a lumbar brace. The request IS NOT medically necessary.

Purchase of Interferential Unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines interferential current Page(s): 111-120.

Decision rationale: This patient presents with low back pain. The treater is requesting PURCHASE OF INTERFERENTIAL UNIT. The RFA was not made available for review. The patient's stated injury is from 11/18/2014 and he is currently on modified duty. The MTUS guidelines page 111 to 120 states that interferential current stimulation is 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. In addition, a one-month trial may be appropriate to permit the treater to study the effects and benefits of its use. The records do not show any previous request for an interferential unit. The report making the request was not made available. The patient has not trialed interferential unit in the past. In this case, the patient has not tried this modality in the past and a trial is recommended prior to its purchase. The request IS NOT medically necessary.

Purchase of Hot and Cold Unit Low Back: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index 11th Edition (Web), 2014 Pain Chapter, Interferential Current Stimulation (ICS), Cold/Heat packs.

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 on Cold/Heat Packs.

Decision rationale: This patient presents with low back pain. The treater is requesting PURCHASE OF HOT AND COLD UNIT LOW BACK. The RFA was not made available for review. The patient's stated injury is from 11/18/2014 and he is currently on modified duty. The MTUS and ACOEM Guidelines are silent with regards to this request. However, ODG Guidelines under the Low Back chapter on Cold/Heat Packs recommends at-home, local applications of cold pack in the first few days of acute complaints; thereafter, applications of heat packs. ODG further states that mechanical circulating units with pumps have not been proven to be more effective than passive hot/cold therapy. The records do not show any previous request for a hot and cold unit. The report making the request was not made available. In this case, the

ODG guidelines do not recommend mechanical circulating units over passive hot/cold therapy.
The request IS NOT medically necessary.