

<b>Case Number:</b>	CM15-0148295		
<b>Date Assigned:</b>	08/13/2015	<b>Date of Injury:</b>	10/18/2013
<b>Decision Date:</b>	09/11/2015	<b>UR Denial Date:</b>	07/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/30/2015

### 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: Tennessee, Florida, Ohio  
Certification(s)/Specialty: Surgery, Surgical Critical Care

### 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 injured worker is a 52 year old male who reported an industrial injury on 10-18-2013. His diagnoses, and or impression, were noted to include: lumbosacral disc herniation with radiculopathy. No current imaging studies were noted. His treatments were noted to include: medication management; and rest from work. The progress notes of 6-15-2015 reported complaints of mild left shoulder pain, and moderate back pain, left > right, associated with weakness, numbness and tingling; and that he was sick and tired of the back pain minimizing his ability to walk long distances. Objective findings were noted to include: an abnormal toe and heel walk; tenderness in the lumbar para-spinous musculature and mid-line lumbar spine; positive spasms over the lumbar spine that was with decreased range-of-motion and spasms; decreased sensation I the foot and posterolateral calf; sacroiliac tenderness on compression; positive sciatic nerve compression test; and positive bilateral straight leg raise. The physician's requests for treatments were noted to include electromyogram and nerve conduction velocity studies of the lower extremities; and post-operative evaluation, re-evaluation, lumbar corset, and ice unit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Associated Surgical Services: EMG (electromyography)/ NCV (nerve conduction velocity), Bilateral Lateral 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: Low Back.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) EMG/NCS.

**Decision rationale:** There is not sufficient clinical information provided to justify the medical necessity of a repeat EMG study for this patient. The clinical records submitted do not support the fact that this patient had evidence of a prior abnormal EMG study, despite documentation of neurogenic symptoms. The California MTUS guidelines and the ACOEM Guidelines do not address the topic of EMG studies. According to the Official Disability Guidelines (ODG): "The American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) recommends the following minimum standards: The number of tests performed should be the minimum needed to establish an accurate diagnosis." This patient has already been documented to have a negative EMG, which demonstrated no evidence of radiculopathy. The medical documentation reflects that the patient's symptoms are similar to those which were recorded prior the patient's first EMG. A diagnosis of no radiculopathy has been established. A repeat EMG is not indicated by ODG and AANEM guidelines. Therefore, based on the submitted medical documentation, the request for EMG is not medically necessary.

**Associated Surgical Services: Post operative evaluation by an RN (registered nurse): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home health services Page(s): 51.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services Page(s): 51.

**Decision rationale:** There is not sufficient clinical information provided to justify the medical necessity of a post-operative Home Health RN for this patient. The clinical records submitted do not support the fact that this patient requires post-operative Home Health nursing services because the patient has not yet had surgery. The California MTUS Guidelines state that Home Health Services are recommended only for medical treatment of "patients who are homebound, on a part-time or " intermittent "basis, generally up to no more than 35 hours per week." Medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. This patient has been recommended to a surgical lumbar decompression. The medical documentation indicates that this patient has not yet undergone spinal surgery. The patient's last surgery (shoulder repair) was in April, more than 5 months ago. The patient has had a functional improvement in his daily routine since this operation. Post-

operative nursing care is thus inappropriate. Therefore, based on the submitted medical documentation, the request for a home health RN is not medically necessary.

**Associated Surgical Services: Lumbar corset: Overturned**

**Claims Administrator 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 - Lumbar supports.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Lower Back Pain, Acute & Chronic, Lumbar Support.

**Decision rationale:** There is sufficient clinical information provided to justify the medical necessity of a lumbar corset for this patient. The California MTUS guidelines and the ACOEM Guidelines do not address the topic of lumbar corsets. According to the Official Disability Guidelines (ODG), lumbar supports (corsets) are: "recommended as a treatment for compression fractures and specific spondylolisthesis and for treatment of nonspecific lower back pain." This patient has been found to have nonspecific lower back pain, which had no evidence of radiculopathy on EMG studies. Physical exam confirmed the presence of clinical symptoms consistent with the patient's reported injury; including decreased range of motion and back spasms. Therefore, based on the submitted medical documentation, the request for lumbar corset is medically necessary.

**Associated Surgical Services: Ice unit: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Lower Back Pain (acute & chronic), Cold/heat packs.

**Decision rationale:** There is not sufficient clinical information provided to justify the medical necessity of ice therapy for this patient. The clinical records submitted do not support the fact that this patient has acute back pain, which would be amenable to cryotherapy. The California MTUS guidelines and the ACOEM Guidelines do not address the topic of ice packs. According to the Official Disability Guidelines (ODG): "The evidence for the application of cold treatment to low-back pain is more limited than heat therapy. There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function." Since Ice packs are not recommended for treatment of low back pain, their use is contraindicated for this patient. Therefore, based on the submitted medical documentation, the request for an ice pack is not medically necessary.

**Associated Surgical Services: Post operative Physical Therapy, 2 times wkly for 4 wks, 8 sessions, Lumbar Spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

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

**Decision rationale:** There is not sufficient clinical information provided to justify the medical necessity of physical therapy for this patient. The California MTUS Guidelines for physical medicine state that: "Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels." Guidelines also state that practitioners should, "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." This patient has previously had physical therapy, but now his physician is requesting an additional 8 sessions. The guidelines recommend fading of treatment frequency with transition to a home exercise program, which this request for a new physical therapy plan does not demonstrate. Furthermore, the therapy requested is for post-operative physical therapy. This patient has not yet had spinal surgery. Therefore, based on the submitted medical documentation, the request for post-operative physical therapy is not medically necessary.

**Associated Surgical Services: Post operative Acupuncture, 8 sessions, Lumbar Spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** There is not sufficient clinical information provided to justify the medical necessity of post-op acupuncture for this patient. The clinical records submitted do not support the fact that this patient has undergone surgery to support post-operative acupuncture. In accordance with California MTUS Acupuncture guidelines: "Frequency and duration of acupuncture or acupuncture with electrical stimulation may be performed as follows: (1) Time to produce functional improvement: 3 to 6 treatments. (2) Frequency: 1 to 3 times per week. (3) Optimum duration: 1 to 2 months. (d) Acupuncture treatments may be extended if functional improvement is documented." This patient has been recommended to receive spinal decompression. The medical documentation does not support that the patient has undergone surgery. He has also not had documentation of functional improvement after 3-6 prior acupuncture sessions. The need for extra acupuncture sessions above the MTUS recommended initial 3-6 sessions is not supported. Therefore, based on the submitted medical documentation, the request for post-operative acupuncture is not medically necessary.