

Case Number:	CM15-0149310		
Date Assigned:	08/12/2015	Date of Injury:	12/04/2006
Decision Date:	09/17/2015	UR Denial Date:	07/29/2015
Priority:	Standard	Application Received:	07/31/2015

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: New Jersey, New York
 Certification(s)/Specialty: Family Practice

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 47-year-old male who sustained an industrial injury on December 4, 2006 resulting in neck and radiating low back pain. He was diagnosed with thoracolumbar and lumbosacral musculoligamentous sprain or strain with bilateral lower extremity radiculitis, and cervical trapezial musculoligamentous sprain or strain. Documented treatment has included physical therapy without reported benefit, epidural injection, medication which he stated enabled him to participate in activities of daily living, and a home exercise program. The injured worker continues to present with severe radiating back pain. The treating physician's plan of care includes electromyography and nerve conduction velocity studies of bilateral upper and lower extremities; Colace 100 mg; and, 42 home care assistance visits for 5 hours per day, 7 days per week. He is not presently working.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268 and 269.

Decision rationale: The request for EMG/NCS of bilateral upper extremity is medically unnecessary. As per MTUS guidelines, special studies are not needed for true hand and wrist problems until 4-6 weeks of conservative care and observation. There was no documentation of complaints of the upper extremities. That patient had normal strength, sensation, and reflexes of bilateral upper extremities. There were no neurological deficits present during the exam. These reasons make the use of EMG/NCS medically unnecessary and unlikely to provide any additional helpful information.

EMG/NCV bilateral lower extremities: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303, 304 and 309.

Decision rationale: The request for an EMG/NCV of the lower extremities is considered medically necessary. EMG/NCV is used to clarify nerve root dysfunction and is not indicated for obvious radiculopathy. The chart mentions that he had lower back pain with decreased strength, absent reflexes and decreased sensation in specific dermatomes that was corroborated with radiographic findings. He had a lumbar MRI and CT scan showing foraminal stenosis and nerve root impingement. Therefore, the request is considered medically necessary.

Colace 100mg #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pharmacological Therapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Opioid-induced constipation treatment.

Decision rationale: The request is considered medically necessary. ODG guidelines were used as MTUS does not address use of stool softeners. Colace is a stool softener used for opioid-induced constipation. The patient has not been on chronic opioid use. There is no documentation that the patient has constipation requiring this medication. Therefore, the request is considered not medically necessary at this time.

42 Home Care Assistance Visits for 5hrs per day 7 days per week: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medicare Benefits Manual (Rev 144, 05/06/11), Chapter 7, Home Health Services, section 50.2 (Home Health Aid Services).

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

Decision rationale: The request is considered not medically necessary. According to MTUS, home health services are recommended only for otherwise recommended medical treatment for 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. According to the chart, the patient did not have any wounds requiring wound care by a home health aide. There was no skilled nursing need. The patient was able to perform activities of daily living. Therefore, the request is considered not medically necessary.