MAXIMUS Federal Services

Case Number:	CM14-0163008		
Date Assigned:	10/08/2014	Date of Injury:	03/11/2013
Decision Date:	11/07/2014	UR Denial Date:	09/25/2014
Priority:	Standard	Application Received:	10/03/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Physical Medicine and Rehabilitation and is licensed to practice in Massachusetts. 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:

The claimant has a history of a work injury occurring on 03/11/13 when, while lifting a tool box he stepped off a ramp and had left-sided back and groin pain with left leg numbness. Treatments included TENS and chiropractic care with traction. He underwent physical therapy reported as without improvement. Medications included Vicodin. He had been unable to tolerate gabapentin and Flexeril due to side effects.An MRI scan showed findings of a disc herniation and he was considered as a surgical candidate. He continues to be treated for ongoing back pain radiating into the leg with numbness and tingling. He was seen on 04/16/14. Medications included Norco. He had been prescribed Ambien by his primary care physician. There was a pending pain management consult. Physical therapy had been helpful in the past for improving function with decreased pain Physical examination findings included decreased spinal range of motion with positive left straight leg raising. He had decreased lower extremity strength and sensation. Imaging results are referenced as showing a large L5-S1 disc herniation with severe left-sided foraminal stenosis. Authorization for an epidural injection, EMG/NCS testing, acupuncture, and for physical therapy two times per week for three weeks was requested. Norco and gabapentin were prescribed. Authorization for a three month gym membership and psychiatric consultation were also requested.On 05/14/14 he was having ongoing symptoms. Physical examination findings included positive straight leg raising with decreased spinal range of motion. Treatments had included physical therapy and an epidural injection. Authorization for a microdiscectomy and EMG/NCS testing was requested. On 07/30/14 he was having ongoing symptoms. Physical examination findings appear unchanged. A lumbar support was provided. On 08/27/14 the request for a lumbar microdiscectomy had been denied. On 09/24/14 he was having ongoing pain. He had undergone hernia repair surgery. He was also having left shoulder pain. Physical

examination findings included positive left shoulder impingement. He was continued at a modified work. Norco 5/325 mg #120 was prescribed.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV Of The Left Lower Extremity, Left Knee: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines , Low Back Chapter

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

Decision rationale: Electromyography (EMG) testing is recommended as an option and may be useful to obtain unequivocal evidence of radiculopathy. However, as in this case, electromyography is not necessary if radiculopathy is already clinically obvious. Therefore, EMG/NCV of the Left Lower Extremity, Left Knee is not medically necessary.

Acupuncture Two Times A Week For Three Weeks For The Lumbar Spine Quantity: 6: Overturned

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

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

Decision rationale: Guidelines recommend acupuncture as an option when pain medication is reduced or not tolerated or as an adjunct to physical rehabilitation with up to 6 treatments 1 to 3 times per week with extension of treatment if functional improvement is documented. In this case, the claimant has not had prior acupuncture treatment and the number of requested visits is within guideline recommendations. Therefore, this request was medically necessary.

Physical Therapy Two Times A Week For Three Weeks For The Lumbar Spine Quantity: 6: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (1)Chronic pain, Physical medicine treatment. (2) Preface, Physical Therapy Guidelines.

Decision rationale: In this case, the claimant has already had physical therapy treatment without improvement. Patients are expected to continue active therapies at home. Compliance with a home exercise program would be expected and would not require continued skilled physical therapy oversight.Therefore this request was not medically necessary.

Chiropractic Therapy Two Times A Week For Three Weeks For The Lumbar Spine Quantity:: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & Manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-59.

Decision rationale: Chiropractic treatment is recommended for chronic pain if caused by musculoskeletal conditions with a trial of 6 visits with treatment beyond 4-6 visits with documented objective improvement in function. In this case, the claimant has already had chiropractic treatments. There is no documentation of treatments producing improvement in function and therefore the request is not medically necessary.

Gym Program Membership For 3 Months: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability guidelines/Intergrated Treatment Guidelines (ODG Treatment in Worker's Compensation 2nd Edition- Disability Duration Guidelines (9th Edition) Work Loss Data Institute

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

Decision rationale: A gym membership is not recommended as a medical prescription unless a documented home exercise program with periodic assessment and revision has not been effective and there is a need for equipment. If a membership is indicated, continued use can be considered if can be documented that the patient is using the facility at least 3 times per week and following a prescribed exercise program. In this case, there is no documentation of a prescribed exercise program or need for specialized equipment. Therefore, the requested gym membership is not medically necessary.