

Case Number:	CM14-0165757		
Date Assigned:	10/10/2014	Date of Injury:	07/14/2011
Decision Date:	11/12/2014	UR Denial Date:	10/02/2014
Priority:	Standard	Application Received:	10/08/2014

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 Preventive Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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:

This patient is a 28 year old employee with date of injury of 7/14/2011. Medical records indicate the patient is undergoing treatment for sprain in lumbar region; lumbosacral neuritis NOS and postsurgical states NEC. He is s/p L4, S, S1 hemilaminotomy, partial foraminotomy and partial facetectomy. He has been diagnosed with reactive depression. Subjective complaints include numbness at the lateral aspect of the left foot. The patient has low back pain and lower left extremity weakness of long duration. PT has helped in the past. His pain in the lumbar spine is rated 2/10 at best, 5/10 at worst. His lower left extremity symptoms are most prevalent while walking. Objective findings include a positive slump test of the lumbar spine (left) and a positive left straight leg raise. There is moderate tenderness at the left lumbar musculature, left greater than right. His decreased range of motion (ROM) prevents full functional activities and decreased neutral spine position awareness during activities of daily living. Treatment has consisted of 28 sessions of post-operative PT but remains deconditioned. The TENS unit was used 5 days per week and did facilitate in an improved ROM. He completed a 3 week home exercise program to include stretching, heat and cold packs. Medications include: Tramadol ER, Cyclobenzaprine, Naproxen and Pantoprazole. Cymbalta was prescribed to decrease neuropathic pain, somatic pain and depression. The utilization review determination was rendered on 10/2/2014 recommending non-certification of Additional physical therapy twice a week for three weeks for the lumbar spine; EMG/NCV of the bilateral lower extremities and TENS Unit (replacement).

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional physical therapy twice a week for three weeks for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315, Chronic Pain Treatment Guidelines Physical Therapy, Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Physical Therapy

Decision rationale: California MTUS guidelines refer to physical medicine guidelines for physical therapy and recommends as follows: "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." Additionally, ACOEM guidelines advise against passive modalities by a therapist unless exercises are to be carried out at home by patient. ODG quantifies its recommendations with 10 visits over 8 weeks for lumbar sprains/strains and 9 visits over 8 weeks for unspecified backache/lumbago. ODG further states that a "six-visit clinical trial" of physical therapy with documented objective and subjective improvements should occur initially before additional sessions are to be warranted. The patient has had 28 previous PT sessions and continues to have back pain. The treating physician has note detailed functional improvement from previous PT sessions. In addition, the treating physician has not detailed a new injury or re-injury to justify additional PT visits at this time. As such, the request for Additional physical therapy twice a week for three weeks for the lumbar spine is not medically necessary.

EMG/NCV of the bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303, 309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Electrodiagnostic testing (EMG/NCS)

Decision rationale: ACOEM states "Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks." ODG states in the Low Back Chapter and Neck Chapter, "NCS is not recommended, but EMG is recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. Electrodiagnostic studies should be performed by appropriately trained Physical Medicine and Rehabilitation or Neurology physicians. See also Monofilament testing". The patient has a previous EMG authorized but the treating physician did not detail the results of the EMG. In addition the treating physician does not detail why a new EMG/NCV is needed at this time. As such the request for EMG/NCV of The Bilateral Lower Extremities is not medically necessary at this time.

TENS Unit (replacement):

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria use for TENS.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315, Chronic Pain Treatment Guidelines Interferential Current Stimulation, Transcutaneous electrotherapy Page(s): 54, 114-116, 118-120.

Decision rationale: ACOEM guidelines state "Insufficient evidence exists to determine the effectiveness of sympathetic therapy, a noninvasive treatment involving electrical stimulation, also known as interferential therapy. At-home local applications of heat or cold are as effective as those performed by therapists." MTUS further states regarding inferential units, "Not recommended as an isolated intervention" and details the criteria for selection: 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., repositioning, 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." The treating physician's progress note on 5/29/14 indicates that spasms have remained refractory to heat, cold, home exercise, activity modification and TENS. Thus, the patient trialed a TENS unit and the TENS unit failed to decrease symptoms and improve functionality. As such, current request for TENS Unit (replacement) is not medically necessary.