

Case Number:	CM14-0178103		
Date Assigned:	10/31/2014	Date of Injury:	02/09/2014
Decision Date:	12/08/2014	UR Denial Date:	10/07/2014
Priority:	Standard	Application Received:	10/27/2014

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 & Rehabilitation and Pain Medicine and is licensed to practice in Texas and Ohio. 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 injured worker is a 27-year-old female who reported an injury on 02/09/2014. The mechanism of injury is due to repetition of her customary job duties. The injured worker has diagnoses of lumbar disc disease and right hip rule out internal derangement. Past medical treatment consists of physical therapy, E stim, ultrasound, massage therapy, and medication therapy. Medications consist of cyclobenzaprine 7.5 mg and Fluriflex 180 gm. On 06/16/2014, the injured worker underwent trigger point impedance imaging. Findings revealed 10 clinical relevant trigger points. Trigger point impedance imaging was consistent with lumbar spine and myofascial pain syndrome. On 09/22/2014, the injured worker complained of pain in low back. The physical examination revealed normal gait. There was a positive right straight leg raise and tenderness to the lumbar spine and buttocks. It was also noted that there was tenderness to right hip with decreased range of motion. The injured worker's deep tendon reflexes were symmetrical and equal. The medical treatment plan was for the injured worker to undergo an EMG/NCS of the bilateral lower extremities, lumbar spine, and left buttocks. The provider would also like to see the injured worker receive a pain management consultation. The rationale and Request for Authorization form were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCS of the Bilateral Lower Extremities, Lumbar Spine, Left Buttock,: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 710.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The request for EMG/NCS of The Bilateral Lower Extremities, Lumbar Spine, Left Buttock is not medically necessary. The submitted documentation dated 09/22/2014 did not show any functional deficits the injured worker might be having. Additionally, there were no focal neurologic dysfunction signs submitted upon review. Furthermore, there was no indication of the injured worker having failed any recent conservative care treatment. The submitted report did indicate tenderness to the lumbar spine and buttocks, and a positive right straight leg. However, there was no documentation of the injured worker having been observed 3 weeks to 4 weeks with conservative care treatment. Given the above, the injured worker is not within the California MTUS/ACOEM Guideline criteria. As such, the request is not medically necessary.

Pain Management Consultation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, 2nd Edition Chapter 7 Independent Medical Examinations and Consultations

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral interventions Page(s): 23.

Decision rationale: The request for Pain Management Consultation is not medically necessary. The submitted documentation indicated that the injured worker was obtaining physical medicine treatment. However, there was no evidence of any objective functional deficits. Additionally, the submitted documentation did not indicate that the injured worker was seeking any psychological or psychosocial therapy. Additionally, there was no evidence suggesting that the injured worker had attended any cognitive behavioral therapy for an initial trial of at least 3 visits to 4 visits over a 2 week period. Given the above, the injured worker is not within MTUS recommended guideline criteria. As such, the request is not medically necessary.