

Case Number:	CM14-0184173		
Date Assigned:	11/12/2014	Date of Injury:	11/05/2003
Decision Date:	12/16/2014	UR Denial Date:	10/09/2014
Priority:	Standard	Application Received:	11/05/2014

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 Family Medicine and is licensed to practice in Utah. 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 patient is a 51 year-old male and date of injury is 11/05/2003. The mechanism of injury is not seen in the clinical documents. The patient has been diagnosed with failed post-laminectomy syndrome, myofascial trigger points, depression and lumbar degenerative disc disease. The patient's treatments have included previous injections, imaging studies, and medications. The undated clinical documents state that legs weaker L>R and back better with epidural on 5/29/2014. The physical exam findings June 20, 2014 states he is moderate distress. The lumbar spine exams show he walks with an antalgic gait towards the left. He is noted to be weaker in the left leg compared to the right. The scar appears to be well-healed in the midline lumbar spine. The range of motion of the lumbar spine is reported with forward flexion to 25 and extension beyond neutral. Neurological exam is reported as 2+ at the knees on the right and left. The patient's medications have included, but are not limited to, Omeprazole, Duexis, Lidoderm, a compounded medication, Ibuprofen and Gabapentin.

IMR ISSUES, DECISIONS AND RATIONALES

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

Repeat transforaminal LESI (lumbar epidural steroid injection) left L3 and L4:
Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310.

Decision rationale: MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for an injection. MTUS guidelines state the following: "Epidural corticosteroid injections for radicular pain, to avoid surgery." According to the clinical documentation provided and current MTUS guidelines, an injection is indicated as a medical necessity to the patient at this time.

EMG (Electromyography)/NCV (Nerve Conduction Velocity) bilateral lower extremities:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back

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

Decision rationale: The current request is for EMG of the bilateral lower extremities. MTUS guidelines were reviewed in regards to this specific case. Clinical documents were reviewed. According to the clinical documents, there is some evidence of decreased reflexes in the lower extremities. The guidelines also state EMG for clinically obvious radiculopathy is not recommended. The clinical documents are lacking evidence of "red flag symptoms" or worsening symptoms. There is no clinical documentation evidence for indication of EMG testing at this time. The request is not indicated as a medical necessity at this time.

Physical therapy 2 times 3: Upheld

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

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

Decision rationale: MTUS guidelines state the following regarding physical therapy: "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks; Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2): 8-10 visits over 4 weeks; Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks." The clinical documents state the injury was over 10 years ago. It is unclear the goals or specific injury that will be treated in the request. The requested also has been modified to give ample time for the patient to learn a home exercise program. According to the clinical documentation provided and current MTUS guidelines, physical therapy is not indicated as a medical necessity to the patient at this time.