MAXIMUS Federal Services

Case Number:	CM14-0184838		
Date Assigned:	11/12/2014	Date of Injury:	08/19/2014
Decision Date:	12/30/2014	UR Denial Date:	10/21/2014
Priority:	Standard	Application Received:	11/06/2014

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 Occupational Medicine and is licensed to practice in California. 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 is a 39-year-old male with an 8/18/14 date of injury. The mechanism of injury was a fall. The progress note dated 9/24/14 stated that the patient had a course of physical therapy, with minimal improvement in his symptoms. The patient was seen on 10/1/14 with complaints of constant burning pain in the upper, mid and low back, radiating down to the right hip and right lower extremity. The patient also reported constant burning, pins and needles-like pain, in the right leg, radiating down to the right foot, and associated weakness. Exam findings revealed tenderness and spasms of the thoracolumbar spine, decreased range of motion of the thoracolumbar spine and tenderness about the greater trochanteric bursa. The sensation in the right L5-S1 dermatomes was diminished. The diagnosis is persistent thoracolumbar pain and right-sided greater trochanteric bursitis. Treatment to date: work restrictions, acupuncture, physical therapy and medications. An adverse determination was received on 10/21/14. The request for EMG/NCV of the bilateral lower extremities was modified to an EMG of the right lower extremity only given, that the patient complained only of right-sided extremity pain. The request for thoracolumbar bone scan and physical therapy were denied, however the determination page was not available for the review.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV of the bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines- Low back

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

Decision rationale: CA MTUS states that electromyography (EMG), including H-reflex tests, are indicated to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three to four weeks. In addition, ODG states that EMGs may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious. However the patient had subjective and objective radicular complaints only to the right lower extremity. In addition, the patient was certified for an MRI of the lumbar spine, but the results were not available for the review. Additionally, the Guidelines state that NCS are not recommended when a patient is presumed to have symptoms on the basis of radiculopathy. Lastly, the UR decision dated 10/21/14 certified an EMG of the right lower extremity. Therefore, the request for EMG/NCV of the bilateral lower extremities was not medically necessary.

Thoracolumbar bone scan: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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 Chapter, Bone Scan

Decision rationale: CA MTUS does not address this issue. ODG states that Bone scans use intravenous administration of tracer medications to show radioactive uptake to detect metastases, infection, inflammatory arthropathies, significant fracture, or other significant bone trauma. Bone scans are not recommended, except for bone infection, cancer, or arthritis. The physician requested the bone scan to exclude a subclinical fracture of the thoracolumbar spine. However, the guidelines do not recommend bone scan for this clinical scenario. In addition, there is a lack of documentation indicating a significant fracture, infection, cancer or arthritis. Therefore, the request for Thoracolumbar bone scan was not medically necessary.

Physical Therapy times 6 for the Thoracolumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines- Physical Therapy

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

Decision rationale: CA MTUS stresses the importance of a time-limited treatment plan with clearly defined functional goals, frequent assessment and modification of the treatment plan based upon the patient's progress in meeting those goals, and monitoring from the treating physician regarding progress and continued benefit of treatment is paramount. However, the progress note dated 9/24/14 stated that the patient had a course of physical therapy with minimal improvement in his symptoms. Given this information it is not clear, why an additional sessions of physical therapy were requested. Therefore, the request for Physical Therapy times 6 for the Thoracolumbar spine was not medically necessary.