

Case Number:	CM14-0218016		
Date Assigned:	01/07/2015	Date of Injury:	02/25/2011
Decision Date:	03/06/2015	UR Denial Date:	12/04/2014
Priority:	Standard	Application Received:	12/30/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

According to the records made available for review, the injured worker is a 66 year-old male with a date of injury of 02/25/2011. The results of the injury include pain in the cervical spine, bilateral shoulders, and lumbar spine. Diagnoses have included cervical fracture, status post emergent C3-C4 anterior discectomy and cervical fusion; severe lumbar spondylosis; and bilateral rotator cuff syndrome/adhesive capsulitis. Treatments have included medications, cortisone injections, TENS unit, physical therapy, home exercise program, and surgical intervention. Medications have included Norco, Ibuprofen, Flexeril, Tramadol, and Lidoderm patches. Surgical interventions have included C3-C4 anterior discectomy and cervical fusion, performed in 2011. A progress note from the treating physician, dated 11/13/2014, documents an evaluation of the injured worker. The injured worker reported neck pain with right upper extremity radiating pain and weakness; low back pain with right leg radiating symptoms with weakness; difficulty with gait; bilateral shoulder pain; sleep problems; depression; and difficulty completing self-care activities. Objective findings included unstable, antalgic gait and wheeler dependent; unable to walk on toes and heels; positive Romberg; cervical spine muscle guarding and tenderness; cervical spine range of motion on right and left lateral rotation is 20/70, lateral flexion is 5/30, extension is 20/60, and flexion is 20/60; bilateral acromioclavicular joint and supraspinatus tendon tenderness to palpation; positive right and left shoulder impingement sign; decreased range of motion of bilateral shoulders; lumbar spine with diffuse muscle guarding and tenderness; decreased range of motion of the lumbar spine; referred back pain with straight leg raise with minimal leg elevation; hypoesthesia in the right lower extremity; piriformis

tenderness; right lower extremity fasciculations; and right leg tremor. The treating physician documented that cervical spine x-rays revealed anterior fixation device at C3-4, moderate degenerate vertebral body and disc space narrowing at C5-6 and C6-7; and anterior osteophyte at C5-6. Lumbar spine x-rays were noted to reveal levoscoliotic deformity; large anterior L1-2 osteophyte; and moderate L4-5 anterior spondylolisthesis with severe L5-S1 disc space loss. Work status is listed as currently not working. Treatment plan was documented to include updated cervical MRI; MRI of the lumbar spine as well as lower extremity electrodiagnostic studies; non-skilled home care attendant care; prescription for Baclofen for symptoms related to myelopathy; and follow-up evaluation. Request is being made for a prescription for One EMG/NCS of the bilateral lower extremities and a prescription for One non skilled home attendant care. On 12/04/2014, Utilization Review non-certified a prescription for One EMG/NCS of the bilateral lower extremities. Utilization Review non-certified a prescription for One EMG/NCS of the bilateral lower extremities based on the limited diagnostic accuracy in detecting herniated discs along with the limited evidence of the procedure as a whole. As well, the testing does not appear necessary if the symptoms of radiculopathy are already clinically evident with physical exam. The Utilization Review cited the ACOEM Guidelines, Chapter 12 (Low Back Complaints (2004): Nerve Conduction Studies (NCS); and Official Disability Guidelines, Low Back-Lumbar and Thoracic (Acute and Chronic): EMGs (electromyography). Utilization Review non-certified a prescription for One non skilled home attendant care. Utilization Review non-certified a prescription for One non skilled home attendant care based on the lack of documentation to support the selection criteria for the service. The Utilization Review cited the Medicare Benefits Manual (Rev. 144, 05-06-11), Chapter 7: Home Health Services; section 50.2 (Home Health Aide Services). Application for independent medical review was made on 12/30/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

One EMG/NCS of the bilateral lower extremities: Overturned

Claims Administrator 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, Lumbar & Thoracic (Acute & Chronic) EMGs (electromyography)

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

Decision rationale: The patient presents with back pain rated 8/10 with right leg radiating symptoms. The request is for ONE EMG/NCS OF THE BILATERAL LOWER EXTREMITIES. Patient's diagnosis on 11/13/14 included severe lumbar spondylosis. Patient's gait is unstable, antalgic and wheeler dependant. Physical examination to the lumbar spine on 11/13/14 revealed decreased range of motion, especially on extension 5 degrees. Positive straight leg raise test bilaterally with minimal elevation. Patient's medications include Ibuprofen and Flexeril, per treater report dated 11/13/14. The patient is temporarily totally disabled. For EMG, ACOEM Guidelines page 303 states Electromyography, including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms

lasting more than 3 or 4 weeks." Per progress report dated 11/13/14, treater requests "electrodiagnostic studies with worsening right leg weakness, fasciculations, and tremor." UR letter dated 12/04/14 states "...the limited diagnostic accuracy in detecting herniated discs is the primary concern along with evidence of the procedure as a whole. Radiculopathy is present with physical exam and it does not appear necessary if the symptoms are already clinically evident..." However, ACOEM supports this testing for patients presenting with low back pain. The patient continues with low back pain, and there is no documentation that patient has had prior EMG/NCV studies. The request appears to meet guideline criteria. Therefore, the request IS medically necessary.

One non-skilled home attendant care: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medicare Benefits Manual (Rev. 144, 05-06-11), Chapter 7- Home Health Services; section 50.2 (Home Health Aide Services)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines home service Page(s): 51.

Decision rationale: The patient presents with back pain with right leg radiating symptoms, neck pain with right upper extremity radiating pain, difficulty with gait, bilateral shoulder pain, sleep problems and depression. The request is for ONE NON/SKILLED HOME ATTENDANT CARE. The patient is status post emergent Anterior Cervical Discectomy Fusion 2011. Patient's diagnosis on 11/13/14 included severe lumbar spondylosis. Patient's gait is unstable, antalgic and wheeler dependant. Physical examination to the lumbar spine on 11/13/14 revealed decreased range of motion, especially on extension 5 degrees. Positive straight leg raise test bilaterally with minimal elevation. Patient's medications include Ibuprofen and Flexeril, per treater report dated 11/13/14. The patient is temporarily totally disabled. MTUS Guidelines, page 51, has the following regarding home service, Recommended only for otherwise recommended medical treatments for patients who are home bound on a part-time or intermittent basis, generally up to no more than 35 hours per week. Medical treatment does not include homemaker services like shopping, cleaning, laundry, and personal care given by homehealth aides like bathing, dressing, and using the bathroom when this is the only care needed. Per progress report dated 11/13/14, the patient "has substantial difficulty completing any self care activities. He reports that a woman whom he rents a room assists with bathing, showering, meal preparation, and cleaning his home. He is unable to drive. he has been depressed and has insomnia." The patient "requires non-skilled home care attendant care," per progress report dated 11/13/14. However, there is no documentation as to why the patient is unable to perform self-care. It does not appear the patient is home bound. Without adequate diagnostic support for the needed self care such as loss of function of a limb or mobility, the requested home health care would not be indicated. The MTUS guidelines are clear that Home Care is for medical treatment only. There is no documentation found in the reports provided that the patient requires medical treatment at home. Therefore, the request IS NOT medically necessary.

