

Case Number:	CM14-0208200		
Date Assigned:	12/19/2014	Date of Injury:	03/09/2013
Decision Date:	02/17/2015	UR Denial Date:	11/13/2014
Priority:	Standard	Application Received:	12/11/2014

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 and Rehabilitation, has a subspecialty in Interventional spine 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:

The patient is a 66 year old male with an injury date of 03/09/13. Based on the 09/30/14 progress report provided by treating physician, the patient complains of low back pain. The patient ambulates with a guarded gait. Physical examination to the lumbar spine revealed restricted range of motion in all planes, secondary to pain and stiffness. Per progress report dated 09/30/14, treater is requesting physical therapy for the neck and low back, focusing on strength training, increasing range of motion and decreasing pain. EMG/NCV of the lower extremity is requested to rule out radiculopathy. Interferential unit is requested for home use and pain relief purposes. The patient is temporarily totally disabled. Diagnosis 09/30/14- cervical spine intervertebral disc disorder- lumbar spine disc bulge- lumbar spine disc extrusion- lumbar spine radiculitis- right shoulder tendonitis and impingement- the patient has a history of non-industrial diabetes, hypertension, for which he treats with his primary care physician. The utilization review determination being challenged is dated 11/13/14. Treatment report dated 09/30/14 was provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV (Electromyography, or Nerve conduction velocity) Lower Extremities:

Overturned

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

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

Decision rationale: The patient presents with low back pain. The request is for EMG/NCV (electromyography, or nerve conduction velocity) lower extremities. Patient's diagnosis on 09/30/14 included cervical spine intervertebral disc disorder, lumbar spine disc bulge, lumbar spine disc, and extrusion lumbar spine radiculitis. The patient ambulates with a guarded gait. Physical examination to the lumbar spine on 09/30/14 revealed restricted range of motion in all planes, secondary to pain and stiffness. 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." UR letter dated 11/13/13 states "there is no evidence of significant neurologic dysfunction that would necessitate this request." ACOEM supports this testing for patients presenting with low back pain, however. Per progress report dated 09/30/14, treater is requesting EMG/NCV of the lower extremity to rule out radiculopathy. Patient continues with low back pain. There is no documentation that patient has had prior EMG/NCV studies. The request meets guideline criteria. Therefore, the EMG/NCV of the lower extremities is medically necessary.

DME (Durable Medical Equipment) Interspec Interferential Stimulator II and supplies, Purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

Decision rationale: The patient presents with low back pain. The request is for DME (durable medical equipment) interspec interferential stimulator in and supplies purchase. Patient's diagnosis on 09/30/14 included cervical spine intervertebral disc disorder, lumbar spine disc bulge, lumbar spine disc, and extrusion lumbar spine radiculitis. The patient ambulates with a guarded gait. Physical examination to the lumbar spine on 09/30/14 revealed restricted range of motion in all planes, secondary to pain and stiffness. The patient is temporarily totally disabled. MTUS pages 118 to 120 states that Interferential Current Stimulation (ICS) are not recommended as an isolated intervention. MTUS further states, "While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway." It may be appropriate if pain is not effectively controlled due to diminished effectiveness or side effects of medication; history of substance abuse, significant pain due to postoperative conditions; or the patient is unresponsive to conservative measures. A one month trial may be appropriate if the above criteria are met. Per progress report dated 09/30/14, treater is requesting Interferential unit for home use and pain relief purposes. Provided report appears to show that the requested unit would not be an isolated intervention as the patient is prescribed physical

therapy. However, there is no discussion that pain is not effectively controlled due to the effectiveness of medications (which are not listed nor discussed), substance abuse or pain due to postoperative conditions as required by MTUS. Furthermore, there is no documentation that the patient has trialed one-month use at home. The request does not meet MTUS indications; therefore it is not medically necessary.

Physical Therapy 2 times 3 Neck/Low Back: Upheld

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

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

Decision rationale: The patient presents with low back pain. The request is for Physiotherapy 2 times 3 for the Neck/Low Back. Patient's diagnosis on 09/30/14 included cervical spine intervertebral disc disorder, lumbar spine disc bulge, lumbar spine disc, and extrusion lumbar spine radiculitis. The patient ambulates with a guarded gait. Physical examination to the lumbar spine on 09/30/14 revealed restricted range of motion in all planes, secondary to pain and stiffness. The patient is temporarily totally disabled. MTUS pages 98, 99 have the following: "Physical Medicine: recommended as indicated below. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." MTUS guidelines pages 98, 99 states that for "Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis, and radiculitis, 8-10 visits are recommended." Per progress report dated 09/30/14, treater is requesting physical therapy for the neck and low back, focusing on strength training, increasing range of motion and decreasing pain. However, treater does not discuss treatment history and why therapy is needed. There is no discussion regarding how the patient responded to therapy in the past, number of previous sessions and why home exercise is inadequate. Therefore the request is not medically necessary.