

<b>Case Number:</b>	CM13-0014700		
<b>Date Assigned:</b>	02/05/2014	<b>Date of Injury:</b>	08/15/2011
<b>Decision Date:</b>	04/11/2014	<b>UR Denial Date:</b>	08/09/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/21/2013

### 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, has a subspecialty in Pain 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:

The injured worker is a 42-year-old male with a date of injury on August 15, 2011. The patient has a diagnosis of chronic low back pain with a left L4-L5 herniated disk there is a moderate degree of central and right foraminal stenosis with discogenic changes. On May 2, 2012 the patient underwent and L4-5 laminectomy. It was reported in a progress note on date of service June 21 2013 that the patient had no relief following surgical intervention. The disputed issue in this case is a request for a lumbar MRI. In this injured worker, this request for a lumbar MRI on 7/30/2013 is a repeat study. The patient had previously undergone lumbar MRI on 11/5/2011, which demonstrated L4-5 disc protrusion and resultant neuroforaminal stenosis. The patient since that time has undergone lumbar laminectomy and discectomy at the L4-5 level. The utilization reviewer denied this request, stating, "The MTUS guidelines do not recommend diagnostic studies for screening purposes and there has been no documentation of a current thorough history and objective exam demonstrating evidence of new or worsening lumbar pathology that would warrant evaluation with a repeat MRI and electrodiagnostic study."

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **ONE MRI OF THE LUMBAR SPINE:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation [HTTP://WWW.ODG-TWC.COM/ODGTWC/LOW\\_BACK.HTM#MRIS](http://WWW.ODG-TWC.COM/ODGTWC/LOW_BACK.HTM#MRIS).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Page(s): 6. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) LOW BACK CHAPTER: LUMBAR MRI HEADING

**Decision rationale:** ACOEM Chapter 12 supports imaging of the lumbar spine for: Red flag diagnoses where plain film radiographs are negative or unequivocal objective findings that identify specific nerve compromise on the neurologic examination that do not respond to treatment in patients who would consider surgery. When the neurologic examination is less clear, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. (ACOEM Text, pages 303 and 304 and table 12-8). Table 12-8 also indicates that Lumbar MRI is the "test of choice" for patient with prior back surgery according to a panel interpretation of information (which did not meet evidence for research-based evidence). Lumbar MRI Official Disability Guidelines Indications for imaging -- Magnetic resonance imaging: - Thoracic spine trauma: with neurological deficit - Lumbar spine trauma: trauma, neurological deficit - Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit) - Uncomplicated low back pain, suspicion of cancer, infection, other "red flags" - Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit. - Uncomplicated low back pain, prior lumbar surgery - Uncomplicated low back pain, cauda equina syndrome." In this case, the injured worker's request for a lumbar MRI on 7/30/2013 is a repeat study. The patient had previously undergone lumbar MRI on 11/5/2011, which demonstrated L4-5 disc protrusion and resultant neuroforaminal stenosis. The patient since that time has undergone lumbar laminectomy and discectomy at the L4-5 level. Since this patient has had spine surgery and not much improvement in pain afterwards, an MRI is the test of choice as recommended by ACOEM and Official Disability Guidelines for assessing lumbar pathology following surgical intervention. This request is recommended for certification.

**EMG OF THE BILATERAL LOWER EXTREMITIES:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES-INTEGRATED TREATMENT/DISABILITY DURATION GUIDELINES: LOW BACK - LUMBER & THORACIC (ACUTE & CHRONIC)

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

**Decision rationale:** ACOEM Chapter 12 on page 303 states: "Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks." The update to ACOEM Chapter 12 Low Back Disorders on pages 60-61 further states: "The nerve conduction studies are usually normal in Final Determination Letter for IMR Case Number CM13-0014700 4 radiculopathy (except for motor nerve amplitude loss in muscles innervated by the involved nerve root in more severe radiculopathy and H-wave studies for unilateral S1 radiculopathy). Nerve conduction

studies rule out other causes for lower limb symptoms (generalized peripheral neuropathy, peroneal compression neuropathy at the proximal fibular, etc.) that can mimic sciatica." In the case of this injured worker, there has been previous laminectomy in the lumbar spine. The requesting healthcare provider on 6/21/2013 performed a neurologic examination, which demonstrated positive left straight leg raise sign. Deep tendon reflexes were noted to be absent at the left Achilles as well. There was diminished sensation on the anterolateral, posterior lateral aspect of the left lower extremity. Knee muscle strength was noted to be 4 out of 5 on the left and 5 out of 5 on the right. Collectively, this neurologic examination is suggestive of possible radiculopathy, and in electromyography of the bilateral lower extremities would be helpful in further characterizing the specific

**NCV (SENSORY) OF THE BILATERAL LOWER EXTREMITIES:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES-INTEGRATED TREATMENT/DISABILITY DURATION GUIDELINES: LOW BACK - LUMBER & THORACIC (ACUTE & CHRONIC).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Page(s): 303.

**Decision rationale:** ACOEM Chapter 12 on page 303 states: "Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks." The update to ACOEM Chapter 12 Low Back Disorders on pages 60-61 further states: "The nerve conduction studies are usually normal in radiculopathy (except for motor nerve amplitude loss in muscles innervated by the involved nerve root in more severe radiculopathy and H-wave studies for unilateral S1 radiculopathy). Nerve conduction studies rule out other causes for lower limb symptoms (generalized peripheral neuropathy, peroneal compression neuropathy at the proximal fibular, etc.) that can mimic sciatica." In the case of this injured worker, there has been previous laminectomy in the lumbar spine. The requesting healthcare provider on 6/21/2013 performed a neurologic examination, which demonstrated positive left straight leg raise sign. Deep tendon reflexes were noted to be absent at the left Achilles as well. There was diminished sensation on the anterolateral, posterior lateral aspect of the left lower extremity. Knee muscle strength was noted to be 4 out of 5 on the left and 5 out of 5 on the right. Collectively, this neurologic examination is suggestive of possible radiculopathy. In cases of pure radiculopathy, the sensory nerve conduction studies are expected to be normal since the pathology is proximal to the dorsal root ganglion. Nonetheless, guidelines and standards of care recommend the testing of sensory nerve conduction studies in examinations for lumbar radiculopathy because normal sensory NCS's would point to radiculopathy as the sole diagnosis, whereas abnormal sensory nerve conduction studies would suggest a secondary neurologic process as well such as polyneuropathy or mononeuritis. This request is recommended for certification.

**NCV (MOTOR) OF THE BILATERAL LOWER EXTREMITIES:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES-

## INTEGRATED TREATMENT/DISABILITY DURATION GUIDELINES: LOW BACK - LUMBER & THORACIC (ACUTE & CHRONIC).

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

**Decision rationale:** ACOEM Chapter 12 on page 303 states: "Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks." The update to ACOEM Chapter 12 Low Back Disorders on pages 60-61 further states: "The nerve conduction studies are usually normal in radiculopathy (except for motor nerve amplitude loss in muscles innervated by the involved nerve root in more severe radiculopathy and H-wave studies for unilateral S1 radiculopathy). Nerve conduction studies rule out other causes for lower limb symptoms (generalized peripheral neuropathy, peroneal compression neuropathy at the proximal fibular, etc.) that can mimic sciatica." In the case of this injured worker, there has been previous laminectomy in the lumbar spine. The requesting healthcare provider on 6/21/2013 performed a neurologic examination, which demonstrated positive left straight leg raise sign. Deep tendon reflexes were noted to be absent at the left Achilles as well. There was diminished sensation on the anterolateral, posterior lateral aspect of the left lower extremity. Knee muscle strength was noted to be 4 out of 5 on the left and 5 out of 5 on the right. Collectively, this neurologic examination is suggestive of possible lumbar radiculopathy. In cases of pure radiculopathy, the motor nerve conduction studies are expected to be normal since the pathology is proximal to the dorsal root ganglion. Nonetheless, guidelines and standards of care recommend the testing of motor nerve conduction studies in examinations for lumbar radiculopathy because motor sensory NCS's would point to radiculopathy as the sole diagnosis, whereas abnormal motor nerve conduction studies would suggest a secondary neurologic process as well such as polyneuropathy or mononeuritis. Furthermore, when there is severe compromise of the S1 nerve root, H-reflexes (which are a motor and sensory nerve conduction test), may become prolonged. This request is recommended for certification.