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| Case Number: | CM13-0020628 | | |
| Date Assigned: | 12/11/2013 | Date of Injury: | 06/06/2011 |
| Decision Date: | 01/22/2014 | UR Denial Date: | 08/29/2013 |
| Priority: | Standard | Application Received: | 09/05/2013 |

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Neurology and is licensed to practice in Massachusetts, Ohio and Texas. 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 physician 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 35-year-old male who reported an injury on 06/06/2011. The clinical documentation dated 06/04/2013, states that the patient was seen for injuries to both his back and neck, which are still bothering him. The patient is taking multiple medications to include fluoxetine, Seroquel, zolpidem, and various pain medications including Vicodin and omeprazole. The patient stated that his medication fluoxetine did help with his depression; however, due to the pain, it actually is making his depression worse. The patient underwent an MRI of the lumbar spine on 01/16/2013, which noted 5 non rib-bearing lumbar vertebra with normal lordosis present. Minimal lumbar levoscoliosis present. Congenital size of the spinal canal is average, the distal conus medullaris and cauda equina appear normal. Under the impression, it states that at the L4-5 level, mild disc degeneration with a 2 mm circumferential bulge and mild facet arthropathy causing mild bilateral foraminal narrowing was noted. At the L3-4 level, mild disc degeneration with the 1 to 2 mm circumferential bulge and minimal facet arthropathy, causing mild bilateral foraminal narrowing was present. At the L5-S1 and T12-L1, mild disc degeneration was noted; but there were no diagnostic procedures, central canal stenosis, or fracture noted. The patient was also not considered a candidate for spinal surgery at this time. The physician is now requesting a repeat MRI of the lumbar spine, as well as an EMG of the bilateral lower extremities, and a repeat NCV of the bilateral lower extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

Repeat MRI of the lumbar spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, MRI

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

Decision rationale: California MTUS does not address magnetic resonance imaging. Therefore, California MTUS at ACOEM and Official Disability Guidelines have been referred to in this case. Under California MTUS at ACOEM, it states that unequivocal objective findings that identify specific nerve compromise on the neurological examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurological examination is less clear; however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging studies. Indiscriminant imaging will result in false positive findings, such as disc bulges, that are not the source of painful symptoms and do not warrant surgery. It further states that if physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consult the selection of an imaging test to define a potential cause such as using an MRI for neural or other soft tissue, or computer tomography, otherwise known as CT, for bony structures. Under Official Disability Guidelines, it states that routine MRIs are not routinely recommended and should be reserved for a significant change in symptoms, and/or finding suggestive of significant pathology; for example, tumor, infection, fracture, neuro compression, and recurrent disc herniation. The patient has been diagnosed as having acute and chronic pain, chronic pain syndrome, and a depressive disorder secondary to the pain with some dyssomnia or an inability to sleep. However, the documentation does not indicate the patient has had a significant change in his pathology to warrant an additional MRI at this time. His pain level has remained the same over two visitation dates, one was 05/03/2013, and the other was 05/29/2013. His most recent documentation did not even verify what the patient's pain level was at that time. Considering it has been nearly half a year since the patient's most recent clinical evaluation, it is unclear what the patient's current physical status is at this time. As such, the requested service is not deemed medically necessary.

. Repeat EMG of the bilateral lower extremities: Upheld

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): s 303-305.

Decision rationale: Under California MTUS, it states that electromyography, including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunctions in patients with low back symptoms lasting more than 3 or 4 weeks. Under Official Disability Guidelines, it states that EMGs are recommended as an option for the low back. This testing may be useful to obtain unequivocal evidence of radiculopathy after one month conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious. The documentation provided for review

does not notate any markedly different changes in the patient's overall pathology to warrant an additional EMG at this time. Therefore, without sufficient objective information identifying major radiculopathy in his bilateral lower extremities, the requested service is not deemed medically necessary at this time.

Repeat NCS of the bilateral lower extremities: Upheld

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): s 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

Decision rationale: California MTUS does not address NCS. Therefore, California MTUS at ACOEM and Official Disability Guidelines have been referred to in this case. Under ACOEM, it states that objective findings that identify specific nerve compromise in the neurological examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who consider surgery an option. Under Official Disability Guidelines, it notes that nerve conduction studies are not recommended, as there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. The patient has been noted as describing some of his associated symptoms as numbness, tingling, bruising, weakness, bowel dysfunction, and headache, some of which are indications of radiculopathy. As such, the request for a repeat EMG and NCS are not considered medically necessary at this time.