

Case Number:	CM13-0057995		
Date Assigned:	12/30/2013	Date of Injury:	02/22/2011
Decision Date:	04/03/2014	UR Denial Date:	10/28/2013
Priority:	Standard	Application Received:	11/26/2013

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 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 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 applicant is a represented [REDACTED] employee who has filed a claim for chronic low back pain reportedly associated with an industrial injury of February 22, 2011. Thus far, the applicant has been treated with the following: Analgesic medications; attorney representation; transfer of care to and from various providers in various specialties; electrodiagnostic testing of September 11, 2013, notable for mild right L5 radiculopathy; MRI imaging of the lumbar spine of August 12, 2013, notable for multilevel degenerative disk disease, multilevel spinal stenosis, L4-L5 disk degeneration with associated moderate-to-severe central canal stenosis; and extensive periods of time off of work. In a Utilization Review Report of October 25, 2013, the claims administrator denied a request for electrodiagnostic testing of the left lower extremity, citing non-MTUS ODG Guidelines, although the MTUS does address the topic. The claims administrator also denied a request for an epidural steroid injection citing misdated and outdated Official Disability Guidelines as originating from the MTUS Chronic Pain Medical Treatment Guidelines. The applicant's attorney subsequently appealed. In a clinical progress note of September 19, 2013, the applicant is described as reporting 7/10 pain. He is presently off of work. He is on Naprosyn, Tizanidine, and Flexeril. A 4/5 left lower extremity strength is appreciated versus 5/5 right lower extremity strength noted. The applicant is asked to obtain a repeat EMG (electromyogram) of left lower extremity. Epidural steroid injection therapy is sought. It is stated that the applicant does have a large disk herniation and already has proven radiculopathy on EMG testing.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV (electromyogram and nerve conduction studies or velocity) of the Lower Extremity: 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): Table 12-8; 309.

Decision rationale: As noted in the MTUS-adopted ACOEM Guidelines in Chapter 12, table 12-8, electrodiagnostic testing for clinically obvious radiculopathy is "not recommended." In this case, the applicant already has clinically evident, radiographically confirmed, and electrodiagnostically corroborated lumbar radiculopathy. Repeat electrodiagnostic testing, by definition, is superfluous, as it would not alter the treatment plan. Therefore, the request is not certified.

Lumbar Epidural Steroid Injection Left Lower Extremity: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

Decision rationale: As noted on page 46 of the Chronic Pain Medical Treatment Guidelines, epidural steroid injections are indicated in the treatment of radiculopathy, preferably that which is radiographically and/or electrodiagnostically confirmed. In this case, the applicant does have symptoms of left-sided lumbar radiculopathy, has radiographic corroboration of the same, has corresponding objective signs on exam, etc. The diagnosis of lumbar radiculopathy has been definitively established, contrary to what was suggested by the claims administrator. It is further noted that, again, contrary to what was suggested by the claims administrator, the MTUS does support up to two diagnostic epidural steroid injections even in those individuals in whom the diagnosis of radiculopathy is not conclusively established. For all of the stated reasons, then, the original utilization review decision is overturned. The request is certified.