Case Number:	CM13-0062083		
Date Assigned:	12/30/2013	**Date of Injury:**	09/02/2011
Decision Date:	05/07/2014	**UR Denial Date:**	11/26/2013
Priority:	Standard	**Application Received:**	12/06/2013

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 30-year-old male with a date of injury of September 2, 2011. The injured worker has diagnoses of chronic low back pain, lumbar spine musculoligamentous sprain, left lower extremity radiculitis, lumbar disc protrusion, bilateral neuroforaminal narrowing, mild central canal stenosis, sacroiliac joints sprain, psychiatric disorder, and sleep complaints. The disputed issues include a request for lumbar MRI and electrodiagnostic studies. A utilization review determination denied these requests. The repeat MRI was not felt to be medically necessary since "repeat MRI should be reserved for a significant change in symptoms or if there are signs of a significant pathology." The reviewer noted that the patient had similar leg radicular symptoms during the time of service of the previous lumbar MRI on November 30, 2012. There was no evidence of worsening of symptoms or significant pathology. Pain scores are noted to be lower at the time of this repeat MRI request. Furthermore, the reviewer felt that lumbar radiculopathy was clinically obvious and therefore needle EMG's are "not necessary if radiculopathy is already clinically obvious." The guidelines also do not recommend nerve conduction studies for this diagnosis (according to the reviewer).

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI OF THE LUMBAR SPINE: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303,Chronic Pain Treatment Guidelines.

Decision rationale: Section Â§ 9792. 23.5 Low Back Complaints of the California Code of Regulations, Title 8, page 6 states the following: "The Administrative Director adopts and incorporates by reference the Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12) into the MTUS from the ACOEM Practice Guidelines." 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 are 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). In the case of this injured worker, there has been previous lumbar MRI performed in November 2012. This study demonstrated that there was this desiccation and broad-based posterior disc protrusion at the L4-5 level. There was also some associated neuroforaminal narrowing at this level. A progress note on December 22, 2013 indicates similar symptoms, and similar objective findings of left lumbar radiculopathy. According to the notes, a lumbar epidural steroid injection is anticipated. A repeat lumbar MRI is not recommended for 2 reasons. The first is that there is no documented worsening or significant of the patient's symptoms. The second reason is that a lumbar epidural steroid injection is planned anyhow. It would be best to wait and see if the patient has significant clinical improvement or not from this, and imaging at this juncture would unlikely affect management.

EMG OF THE LEFT 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,Chronic Pain Treatment Guidelines CODE OF REGULATIONS Page(s): 6.

Decision rationale: With regard to EMG/NCS of the lower extremities to evaluate for lumbar radiculopathy, Section Â§ 9792.23.5 of the California Code of Regulations, Title 8, page 6 adopts ACOEM Practice Guidelines Chapter 12. 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." Further guidelines can be found in the Official Disability Guidelines. The Official Disability Guidelines Low Back

Chapter, states the following regarding electromyography: "Recommended as an option (needle, not surface). EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious. (Bigos. 1999) (Ortiz-Corredor. 2003) (Haig. 2005) EMGs may be required by the AMA Guides for an impairment rating of radiculopathy. (AMA 2001)" In the case of this injured worker, there are clinical symptoms and objective findings suggestive of lumbar radiculopathy. Previous lumbar MRI had demonstrated disc protrusion. The patient's plan of care includes a lumbar epidural steroid injection. The clinical diagnosis of lumbar radiculopathy can be made based upon these findings, and it is unclear how electromyography would contribute to the clinical management of this patient's at this juncture. This request is recommended for noncertification.

NCV OF THE LEFT LOWER EXTREMITY: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303, 60-61.

Decision rationale: With regard to EMG/NCS of the lower extremities to evaluate for lumbar radiculopathy, Section Â§ 9792.23.5 of the California Code of Regulations, Title 8, page 6 adopts ACOEM Practice Guidelines Chapter 12. 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." Further guidelines can be found in the Official Disability Guidelines. The Official Disability Guidelines Low Back Chapter, states the following regarding electromyography: "Recommended as an option (needle, not surface). EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious. (Bigos. 1999) (Ortiz-Corredor. 2003) (Haig. 2005) EMGs may be required by the AMA Guides for an impairment rating of radiculopathy. (AMA 2001)" With regard to nerve conduction studies, the Official Disability Guidelines Low Back Chapter states: "Nerve conduction studies (NCS) section: Not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. (Utah. 2006)" However, it should be noted that this guideline has lower precedence than the ACOEM Practice Guidelines which are incorporated into the California Medical Treatment and Utilization Schedule, which do recommend NCS. Therefore, nerve conduction studies are recommended in evaluations for lumbar radiculopathy. In the case of this injured worker, there are clinical symptoms and objective findings suggestive of lumbar radiculopathy. Previous lumbar MRI had demonstrated disc protrusion. The patient's plan of care

includes a lumbar epidural steroid injection. The clinical diagnosis of lumbar radiculopathy can be made based upon these findings, and it is unclear how nerve conduction studies would contribute to the clinical management of this patient's at this juncture. This request is recommended for noncertification.