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| <b>Case Number:</b>   | CM14-0156157 |                              |            |
| <b>Date Assigned:</b> | 09/25/2014   | <b>Date of Injury:</b>       | 11/09/2010 |
| <b>Decision Date:</b> | 10/29/2014   | <b>UR Denial Date:</b>       | 09/09/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 09/22/2014 |

### 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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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 74-year-old female who reported injury on 11/09/2010. The mechanism of injury was a fall. The diagnoses included thoracolumbar spine musculoligamentous sprain/strain, and left lower extremity radiculitis. The past treatments have included acupuncture, home exercise, and cortisone injections. An MRI, dated 04/2012, was noted to show 3 mm to 5 mm disc protrusions at L3-S1 with stenosis and facet arthropathy. A nerve conduction velocities study, dated 09/23/2013, was noted to be negative. The progress note, dated 09/11/2014, noted the injured worker complained of low back pain radiating to the bilateral lower extremities, left greater than right. She reported decreased pain with medication use. The physical exam noted lumbar spine tenderness over the bilateral paravertebral muscles and sacroiliac joints, with spasm. Range of motion of the lumbar spine was measured as flexion 40 degrees, extension to 12 degrees, right side bending to 12 degrees, left side bending to 12 degrees, with a positive straight leg raise, decreased sensation along the bilateral L4-5 dermatomes, with 2+ deep tendon reflexes, and no weakness. Medications included tramadol ER 150 mg 1 to 2 tablets daily as needed for pain, and noted a pain rating of 4/10 with medications and 9/10 without medication. It was also noted that the medication enabled the injured worker to perform her ADLs, improved participation in her home exercise program, and improve her sleep pattern. The treatment plan recommended to continue the home exercise program, and medications. The Request for Authorization form was submitted for review on 08/07/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **1 MRI of the lumbar spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303, 53. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back-Lumbar and Thoracic (Acute and Chronic), MRI

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back, MRIs (magnetic resonance imaging).

**Decision rationale:** The injured worker had low back pain radiating to her bilateral low extremities on the left side greater than the right. The physical exam noted a positive straight leg raise test, decreased in sensation along the bilateral L4-5 dermatomes, 2+ deep tendon reflexes bilaterally, and no motor weakness. An MRI was noted to be performed in 04/2012, and revealed 3 mm to 5 mm disc protrusions at L3-S1 with stenosis and facet arthropathy. The California MTUS/ACOEM Guidelines recommend an MRI for the emergence of a red flag, the physiologic evidence of tissue insult or neurovascular dysfunction (e.g. weakness, edema), failure to progress in a strengthening program intended to avoid surgery, clarification of the anatomy prior to an invasive procedure, or to further evaluate the possibility of potentially serious pathology, such as a tumor. The Official Disability Guidelines further state repeat MRI is not routinely recommended, and should be reserve for a significant change in symptoms and/or findings suggestive of significant pathology. There is no evidence of a red flag, or significant change in the injured worker's condition. There is a lack of evidence of significant weakness, tissue insult, or neurological dysfunction on the physical exam. There is no documentation of failure to progress in a strengthening program. There is no indication of planned surgical intervention involving the lumbar spine. As such, a repeat MRI is not indicated at this time. Therefore, the request is not medically necessary.

## **1 Electromyography (EMG) of the bilateral lower extremities: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back- Lumbar and Thoracic (Acute and Chronic)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305 & 308-310.. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back, Nerve conduction studies (NCS).

**Decision rationale:** The injured worker had low back pain radiating to her bilateral lower extremities, left greater than right. A positive straight leg raise test, decreased sensation along the bilateral L4-5 dermatomes, 2+ deep tendon reflexes and no weakness was noted on the physical exam. The California MTUS/ACOEM Guidelines note nerve conduction study and possibly EMG may be recommended if severe nerve entrapment is suspected on the basis of physical examination, denervation atrophy is likely, and there is failure to respond to conservative treatment. The guidelines note EMG for clinically obvious radiculopathy and surface EMG tests are not recommended. There is a lack of evidence of neurological deficit to

the lower extremities. There is no indication of nerve entrapment. There is a lack of documentation of failure to respond to previous treatments. As such, an EMG of the lower extremities is not indicated at this time. Therefore, the request is not medically necessary.

**1 Nerve conduction study (NCS) of the bilateral lower extremities: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back-Lumbar and Thoracic (Acute and Chronic)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305 & 308-310.. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back, Nerve conduction studies (NCS).

**Decision rationale:** The injured worker had low back pain radiating to her bilateral lower extremities, left greater than right. A positive straight leg raise test, decreased sensation along the bilateral L4-5 dermatomes, 2+ deep tendon reflexes and no weakness was noted on the physical exam. A nerve conduction velocities study, dated 09/23/2013, was noted to be negative. The California MTUS/ACOEM Guidelines note nerve conduction study and possibly EMG may be recommended if severe nerve entrapment is suspected on the basis of physical examination, denervation atrophy is likely, and there is failure to respond to conservative treatment. The guidelines note EMG for clinically obvious radiculopathy and surface EMG tests are not recommended. The Official Disability Guidelines note, the use of NCV in the lower extremities is not recommended. There is a lack of evidence of neurological deficit to the lower extremities. There is no indication of nerve entrapment. There is a lack of documentation of failure to respond to previous treatments. There is no indication that the electrodiagnostic studies are being performed to assess for peripheral neuropathies, which would indicate the need for an NCV. There is no indication of significant change in condition since the previous NCV. As such, a repeat NCV of the lower extremities is not indicated at this time. Therefore, the request is not medically necessary.