

Case Number:	CM15-0100469		
Date Assigned:	06/02/2015	Date of Injury:	07/20/2004
Decision Date:	07/01/2015	UR Denial Date:	05/08/2015
Priority:	Standard	Application Received:	05/26/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California, Indiana, New York
 Certification(s)/Specialty: Internal Medicine

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 71-year-old male, who sustained an industrial injury on July 20, 2004. He reported strong pain with a hot sensation in the left shoulder. The injured worker was diagnosed as having increasing lumbar radiculopathy. Treatment to date has included physical therapy, work modifications, and medications including pain and muscle relaxant. On April 16, 2015, the injured worker complains of severe low back pain with bilateral radicular complaints, which is significantly worsened. He complains of frequent left leg numbness and inability to bend, stoop, and lift. His left shoulder is about the same. The physical exam revealed full range of motion with slightly positive impingement of the left shoulder, diffuse tenderness to palpation of the lumbar area with limited range of motion, a positive bilateral straight leg raise testing at 60 degrees, and pain-free range of motion of all joints of the bilateral lower extremities. The motor strength and sensation of the bilateral lower extremities was normal. The deep tendon reflexes of the bilateral lower extremities were symmetrical. The treating physician noted the MRI of the lumbar spine from September 2010 had revealed bilateral neural foraminal narrowing secondary to posterior disc bulging and facet joint hypertrophy. The treatment plan includes a repeat MRI of the lumbar spine and neurodiagnostic studies of bilateral lower extremities.

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: 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 & Thoracic (Acute & Chronic): MRIs (magnetic resonance imaging) (2015).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-5. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back section, MRI lumbar spine.

Decision rationale: Pursuant to the Official Disability Guidelines, MRI of the lumbar spine is not medically necessary. MRIs of the test of choice in patients with prior back surgery, but for uncomplicated low back pain, with radiculopathy, it is not recommended until after at least one month conservative therapy, sooner if severe or progressive neurologic deficit. Repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and findings suggestive of significant pathology. Indications (enumerated in the official disability guidelines) for imaging include, but are not limited to, lumbar spine trauma, neurologic deficit; uncomplicated low back pain with red flag; uncomplicated low back pain prior lumbar surgery; etc. ACOEM states unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients not respond to treatment and who would consider surgery an option. See the ODG for details. In this case, the injured worker's working diagnosis is increased lumbar radiculopathy. The documentation medical record states the injured worker had prior magnetic resonance imaging scans of the lumbar spine. An MRI of the lumbar spine was performed March 23, 1993; and April 15, 1994. The last MRI lumbar spine was performed September 11, 2010. The MRI showed bilateral neuroforaminal narrowing secondary to disc bulges. There were no significant abnormalities noted radiological. The request for authorization is dated April 30, 2015. The most recent progress note from the treating provider is dated April 16, 2015. Subjectively, the injured worker was last treated by the requesting physician in 2010. Reportedly, symptoms of increased significantly with severe low back pain and bilateral radicular complaints. The left leg feels numb frequently and is considerably worse than he was previously. Range of motion of the lower extremities is normal there is tenderness to palpation over the lumbar spine bilaterally with limited range of motion. Neurologic evaluation is unremarkable. Repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and findings suggestive of significant pathology. There are no new significant objective findings documented in the medical record. There are no unequivocal objective findings that identify specific nerve compromise on the neurologic evaluation. The neurologic evaluation is unremarkable with no objective evidence of radiculopathy. Consequently, absent clinical documentation with a significant change in symptoms and/or objective findings with three prior MRIs of the lumbar spine in the record, MRI lumbar spine is not medically necessary.

One neurodiagnostic studies of 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 & Thoracic (Acute & Chronic): Nerve conduction studies (NCS); EMGs (electromyography) (2015).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back section, EMG/NCV.

Decision rationale: Pursuant to the Official Disability Guidelines, neurodiagnostic studies bilateral lower extremities are not medically necessary. Nerve conduction studies are not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. EMGs 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 ACOEM states unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging if symptoms persist. In this case, the injured worker's working diagnosis is increased lumbar radiculopathy. The documentation medical record states the injured worker had prior magnetic resonance imaging scans of the lumbar spine. An MRI of the lumbar spine was performed March 23, 1993; and April 15, 1994. The last MRI lumbar spine was performed September 11, 2010. The MRI showed bilateral neuroforaminal narrowing secondary to disc bulges. There were no significant abnormalities noted radiological. The request for authorization is dated April 30, 2015. The most recent progress note from the treating provider is dated April 16, 2015. Subjectively, the injured worker was last treated by the requesting physician in 2010. Reportedly, symptoms of increased significantly with severe low back pain and bilateral radicular complaints. The left leg feels numb frequently and is considerably worse than he was previously. Range of motion of the lower extremities is normal there is tenderness to palpation over the lumbar spine bilaterally with limited range of motion. Neurologic evaluation is unremarkable. The documentation in the medical record shows the injured worker had prior nerve conduction studies and EMGs performed September 11, 2010. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Although there are subjective complaints documented in the medical record of left leg numbness, there are no objective findings of radiculopathy. There are no unequivocal findings identifying specific nerve compromise. Consequently, absent clinical documentation with unequivocal findings identifying specific nerve compromise with guideline non-recommendations (minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy), neurodiagnostic studies bilateral lower extremities are not medically necessary.