

Case Number:	CM15-0104697		
Date Assigned:	06/09/2015	Date of Injury:	02/05/2014
Decision Date:	07/10/2015	UR Denial Date:	05/08/2015
Priority:	Standard	Application Received:	06/01/2015

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: New Jersey, Alabama, California
 Certification(s)/Specialty: Neurology, Neuromuscular 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 43 year old male, who sustained an industrial injury on 2/05/2014, while employed as a truck driver, as a result of a motor vehicle accident. The injured worker was diagnosed as having lumbar sprain/strain. Treatment to date has included diagnostics and medications. Magnetic resonance imaging of the lumbar spine (8/04/2014) showed mild to moderate central disc herniation, causing mild to moderate central canal stenosis, and no significant neural foraminal narrowing at L4-5, mild broad based disc bulge at L3-4, causing mild central canal stenosis and mild to moderate bilateral foraminal narrowing, left greater than right. Currently, the injured worker complains of headaches, neck pain with radiation to both shoulders, middle back pain bilaterally, right shoulder pain, pins/needles sensation in the right elbow and forearm, with radiation to the right hand and fingers, pins/needles sensation to the right wrist and hand, radiating to the fingers, right thigh pain associated with numbness and inability to bear weight, right knee pain, right lower leg pain, chest pain from radiating pain of the shoulder, sleep disorder, and anxiety/irritability. Current medications included Ibuprofen, Baclofen/Flurbiprofen, Tylenol with codeine, and Gabapentin/L-carnitine. Exam of the lumbosacral spine noted tenderness to palpation and muscles spasms. Motor exam of the right lower extremities was 4-5/5. Sensory exam deficits to the lumbar spine were not documented. The treatment plan included magnetic resonance imaging of the lumbar spine and electromyogram and nerve conduction studies of the bilateral lower extremities. His work status remained total temporary disability.

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. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, MRIs.

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

Decision rationale: Regarding the indications for imaging in case of back pain, MTUS guidelines stated: Lumbar spine x rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. However, it may be appropriate when the physician believes it would aid in patient management. Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures). Furthermore, and according to MTUS guidelines, MRI is the test of choice for patients with prior back surgery, fracture or tumors that may require surgery. The patient does not have any clear evidence of lumbar radiculopathy or nerve root compromise. There is no change of the clinical examination there is no clear evidence of significant change of the clinical examination of the patient compared to previous examination. There is no change in the patient signs or symptoms suggestive of new pathology. Therefore, the request for MRI of the lumbar spine is not medically necessary.

Electromyograph (EMG) and nerve conduction studies (NCS) of the bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, EMGs (electromyography), Nerve conduction studies (NCS).

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

Decision rationale: According to MTUS guidelines, (MTUS page 303 from ACOEM guidelines), 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. EMG has excellent ability to identify abnormalities related to disc protrusion (MTUS page 304 from ACOEM guidelines). According to MTUS guidelines, needle EMG study helps identify subtle neurological focal dysfunction in patients with neck and arm symptoms. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks (page 178). EMG is indicated to clarify nerve dysfunction in case of suspected disc herniation (page 182). EMG is useful to identify physiological insult and anatomical defect in case of neck pain (page 179). There is no documentation of significant change in symptoms and/or new findings suggestive of a new pathology. There is no clinical documentation suggesting lumbar radiculopathy or peripheral nerve dysfunction in this case. Therefore, the request for Electromyograph (EMG) and nerve conduction studies (NCS) of the bilateral lower extremities is not medically necessary.