

Case Number:	CM15-0142252		
Date Assigned:	08/03/2015	Date of Injury:	03/10/2006
Decision Date:	08/31/2015	UR Denial Date:	06/22/2015
Priority:	Standard	Application Received:	07/22/2015

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 58 year old male, who sustained an industrial injury on 3-10-06. The injured worker has complaints of neck and arm pain. the documentation noted that the injured worker has about 50 percent of neck motion and has pain with palpation particularly at the area of C3-4, right greater than left and sensation in the hands is decreased. The diagnoses have included arthrodesis, C4 through C7; postlaminectomy syndrome; facet arthritis and possible carpal tunnel. Treatment to date has included status post posterior fusion, C6-7; narcotic medications and X-rays appear to be solid fusion and there is no motion at the C6-7 level. The documentation noted that the injured worker had a previous stroke after his neck surgery. The request was for magnetic resonance imaging (MRI) of the lumbar spine and electromyography/ nerve conduction study for bilateral lower extremity.

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): 303-5. 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 diagnoses are cervical radiculopathy; cervicobrachialgia; and lumbar radiculopathy. The date of injury is March 10, 2006. The request for authorization is June 15, 2015. The injured worker had an MRI March 19, 2013. The documentation indicates the injured worker had multiple surgeries including lumbar fusions in 2002 and 2013; and cervical fusion in 2010, 2014 and 2015. The most recent progress note in the medical record is March 19, 2015. There is no contemporaneous clinical documentation on or about the date of request for authorization (June 15, 2015). Subjectively, the injured worker has neck and low back complaints with radicular symptoms. Objectively, there is tenderness to palpation overlying the cervical paraspinal muscle groups. Neurologic evaluation shows mental status, cranial nerves, motor is symmetric and reflexes are diminished in the biceps, triceps and ankles. Sensory is diminished in the bilateral C6-C7 and bilateral L5-S1 distribution. Gait is normal. Coordination was normal. There are no significant focal lower extremity neurologic abnormalities. Repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and findings suggestive of significant pathology. The documentation does not indicate there is a significant change in subjective symptoms or objective findings suggestive of significant pathology to warrant a repeat lumbar MRI. Additionally, there is no contemporaneous clinical documentation on or about the date of request for authorization (June 15, 2015) with an updated physical examination and neurologic evaluation. Consequently, absent contemporary clinical documentation with history and physical findings and documentation indicating a significant change in symptoms and or objective findings suggestive of significant pathology, MRI of the lumbar spine is not medically necessary.

EMG/NCS for bilateral lower extremity: 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. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back section, EMG/NCV.

Decision rationale: Pursuant to the ACOEM and Official Disability Guidelines, bilateral lower extremity EMG/NCS studies 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 diagnoses are cervical radiculopathy; cervicobrachialgia; and lumbar radiculopathy. The date of injury is March 10, 2006. The request for authorization is June 15, 2015. The injured worker had an MRI March 19, 2013. The documentation indicates the injured worker had multiple surgeries including lumbar fusions in 2002 and 2013; and cervical fusion in 2010, 2014 and 2015. The most recent progress note in the medical record is March 19, 2015. There is no contemporaneous clinical documentation on or about the date of request for authorization (June 15, 2015). Subjectively, the injured worker has neck and low back complaints with radicular symptoms. Objectively, there is tenderness to palpation overlying the cervical paraspinal muscle groups. Neurologic evaluation shows mental status, cranial nerves, motor is symmetric and reflexes are diminished in the biceps, triceps and ankles. Sensory is diminished in the bilateral C6-C7 and bilateral L5-S1 distribution. Gait is normal. Coordination is normal. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. As noted above, the worker has pain that radiates to the lower extremities. Objectively, there are no significant neurologic abnormalities. Consequently, consistent with guidelines non-recommendations (minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy), no objective findings of radiculopathy on physical examination and an absent contemporary clinical progress note on or about the date of request for authorization, bilateral lower extremity EMG/NCS studies are not medically necessary