

<b>Case Number:</b>	CM15-0143685		
<b>Date Assigned:</b>	08/04/2015	<b>Date of Injury:</b>	10/16/2002
<b>Decision Date:</b>	09/02/2015	<b>UR Denial Date:</b>	06/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/24/2015

### 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: Texas, New York, California  
 Certification(s)/Specialty: Preventive Medicine, Occupational 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 applicant is a represented [REDACTED] employee who has filed a claim for chronic low back pain reportedly associated with an industrial injury of October 16, 2002. In a Utilization Review report dated June 29, 2015, the claims administrator failed to approve a request for MRI imaging of lumbar spine and electrodiagnostic testing of the left lower extremity. The claims administrator referenced a June 2, 2015 progress note and associated RFA form of the same date in its determination. The applicant's attorney subsequently appealed. The claims administrator's medical evidence file, however, suggested the most recent note on file was in fact dated May 7, 2015; thus, the June 2, 2015 progress note which the claims administrator based its decision upon was not seemingly incorporated into the IMR packet. The applicant's attorney subsequently appealed. On March 20, 2014, the applicant underwent an L3-L4 laminectomy-fusion surgery with exploration of prior L4-L5 fusion. In a handwritten note dated April 7, 2015, the applicant was placed off of work, on total temporary disability, owing to ongoing complaints of low back pain radiating to the bilateral lower extremities. The applicant was asked to pursue aquatic therapy. Norco was renewed. The note was difficult to follow and not altogether legible. On May 6, 2015, the applicant was again placed off of work, on total temporary disability, for additional four to six weeks, owing to ongoing complaints of low back pain radiating to bilateral lower extremities. Positive straight leg raising was appreciated. The applicant had a pending medical-legal evaluation noted, it was reported. There was no mention made of the applicant's need for MRI imaging and electrodiagnostic testing on this date. A doctor's first report (DFR) dated January 27, 2015 was notable for commentary that the applicant

had multi-focal complaints of low back pain, hip pain, knee pain, ankle pain, foot pain, headaches, stress, anxiety, depression, and sleep disturbance. The applicant's past medical history was notable for hypertension, it was suggested, admittedly through preprinted checkboxes.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**MRI of lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines 9792.24.2 Title 8, Effective July 18, 2009.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304.

**Decision rationale:** No, the request for MRI imaging of the lumbar spine was not medically necessary, medically appropriate, or indicated here. As noted in the MTUS Guideline in ACOEM Chapter 12, page 304, imaging studies should be reserved for cases in which surgery is being considered or red flag diagnosis is being evaluated. Here, however, there is no mention of the applicant's actively considering or contemplating any kind of surgical intervention based on the outcome of the study, per a historical progress note of May 6, 2015. While it is acknowledged that the June 2, 2015 progress note on which the article in question was sought was not seemingly incorporated into the IMR packet, the historical notes on file made no mention of the applicant's willingness to consider or contemplate further surgical intervention involving the lumbar spine. Therefore, the request was not medically necessary.

**EMG-NCV of left 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, Chapter 14 Ankle and Foot Complaints Page(s): 308; 377. Decision based on Non-MTUS Citation ACOEM Occupational Medicine Practice Guidelines, 3rd ed., Chronic Pain, pg. 8484.

**Decision rationale:** Similarly, the request for electrodiagnostic testing (EMG-NCV) of left lower extremity was likewise not medically necessary, medically appropriate, or indicated here. As noted in the MTUS Guideline in ACOEM Chapter 12, Table 12-8, page 309, EMG testing is deemed not recommended for applicant's who carry a diagnosis of clinically obvious radiculopathy, as was seemingly present here. The applicant had ongoing lumbar radicular pain complaints present on May 6, 2015, the attending provider reported, following earlier failed lumbar spine surgery. It was not clearly established, in short, why EMG testing was sought, when the applicant already carried a known, established diagnosis of lumbar radiculopathy status post earlier failed spine surgery. While it is acknowledged that the June 2, 2015 progress note which the claims administrator based its decision upon was not seemingly incorporated into the IMR packet, the historical notes on file, including the May 6, 2015 progress note, failed to support or substantiate the EMG component of the request. Similarly, the MTUS Guideline in ACOEM Chapter 14, Table 14-6, page 377 notes that electrical studies (AKA nerve conduction testing) is deemed "not recommended" without clinical evidence of tarsal tunnel

syndrome or other entrapment neuropathy. Here, it appeared, based on the historical notes of May 6, 2015 and January 27, 2015, that lumbar radiculopathy status post earlier failed spine surgery was in fact the sole item on the differential diagnosis list. There was no mention of the applicant carrying superimposed diagnosis or disease process such as tarsal tunnel syndrome or focal entrapment neuropathy. While the Third Edition ACOEM Guidelines chronic pain chapter does support nerve conduction studies (NCV) when there is suspected peripheral systemic neuropathy of uncertain cause, here, however, again, lumbar radiculopathy appeared to be the sole item on the differential diagnosis list. There is no mention of the applicant's having a suspected peripheral neuropathy or generalized neuropathy present on May 6, 2015. A January 27, 2015 progress note did not establish the presence of any disease process such as diabetes, alcoholism, or hypothyroidism, which would heighten the applicant's predisposition toward development of generalized peripheral neuropathy. While it is acknowledged that the June 2, 2015 progress note which the claims administrator based his decision upon was not seemingly incorporated into the IMR packet, the historical information on file failed to support or substantiate the request. Therefore, the request was not medically necessary.