

Case Number:	CM15-0160103		
Date Assigned:	08/26/2015	Date of Injury:	02/13/2014
Decision Date:	09/29/2015	UR Denial Date:	07/28/2015
Priority:	Standard	Application Received:	08/17/2015

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, Florida, 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 injured worker is a 54 year old female who sustained an industrial injury on 02-13-2014. Mechanism of injury occurred when she was rear-ended by a motor vehicle. Diagnoses include L4-5, L5-S1 retrolisthesis-rule out instability, radiculitis, radiculopathy L4-S1, bilateral sacroiliitis, and evaluate-rule out L3 fracture or lesion. Treatment to date has included diagnostic studies, physical therapy, home exercise program, acupuncture and medications. An Electromyography and Nerve Conduction Velocity study of her lower extremities done on 04-27-2015 was normal. On 07-23-2015 an unofficial lumbar spine Magnetic Resonance Imaging showed a positive transitional segment (S1-S2 lowest level), positive retrolisthesis L4-5, L5-S1 and lateral recess stenosis L5-S1. There is a possible hemangioma in L3 (depending on numbering L2 from lowest segment, it's the same, due to transactional segment numbering). Medications include Flexeril, Lyrica, Celebrex, and Norco. A physician progress note dated 07-15-2015 documents the injured worker complains of back pain, bilateral leg pain, and numbness and weakness. She rates his pain as 3-9 out of 10. Deep Tendon reflexes were absent in the bilateral knees and ankles. The extensor Hallucis longus motor strength was graded at 4-5 and she was unable to do single heel raises. There was tenderness to palpation of the lumbar spine. Range of motion was limited and straight leg raising was positive. Faber's was positive bilaterally. Treatment requested is for X-ray of the lumbar spine, Electromyography (EMG) and nerve conduction velocity (NCV) of bilateral lower extremities, and Bone scan of the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

X-ray 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): American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) The California MTUS-ACOEM guides, specifically Chapter 12 for the back, page 303.

Decision rationale: This claimant was injured now 1.5 years ago in a rear-ended motor vehicle accident. Diagnoses included L4-5, L5-S1 retrolisthesis-rule out instability, radiculitis, radiculopathy at L4-S1, bilateral sacroiliitis, and evaluate-rule out L3 fracture or lesion. Treatment to date has included prior diagnostic studies which are unspecified, and with no summary reports, physical therapy, a home exercise program, acupuncture and medications. There is continued back pain, but no signs or symptoms progression noted. The MTUS notes that the criteria for ordering imaging studies are: emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery and clarification of the anatomy prior to an invasive procedure. The patient does not meet these criteria. Further, unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. In this case, there is no documentation of even equivocal neurologic signs. Further, imaging studies to this area had already been accomplished, and the outcomes are not reported. The reason for repeating the study is not clinically clear. The request is not medically necessary.

Bone scan of the lumbar spine: 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, Bone scan.

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, bone scans.

Decision rationale: As shared previously, this claimant was injured now 1.5 years ago in a rear-ended motor vehicle accident. Diagnoses include L4-5, L5-S1 retrolisthesis-rule out instability, radiculitis, radiculopathy L4-S1, bilateral sacroiliitis, and evaluate-rule out L3 fracture or lesion. Treatment to date has included prior diagnostic studies, physical therapy, home exercise program, acupuncture and medications. There is continued back pain, but no progression noted of signs or symptoms. Regarding bones scans, the ODG notes they are under study for Chronic

Regional Pain Syndrome (CRPS) evaluation. There may be changes seen in a bone scan in CRPS, including distinctive patterns of radiotracer uptake. A negative bone scan does not rule out CRPS. The clinical utility of bone scan in CRPS has not been proven in high quality studies, but three-phase nuclear medicine bone scans may help diagnose CRPS. (Horowitz, 2007) The ODG also notes regarding bone scans that they are not recommended, except for bone infection, cancer, or arthritis. I did not find any documentation that CRPS, bone infection, cancer or arthritis were clinical concerns in this case. Also, they are under study for the CRPS. The request is not medically necessary.

Electromyograph (EMG) and nerve conduction velocity (NCV) of 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, Nerve conduction studies.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004). Chapter 12, page 303.

Decision rationale: As shared previously, this claimant was injured now 1.5 years ago in a rear-ended motor vehicle accident. Diagnoses included L4-5, L5-S1 retroisthesis-rule out instability, radiculitis, radiculopathy L4-S1, bilateral sacroiliitis, and evaluate-rule out L3 fracture or lesion. Treatment to date has included prior diagnostic studies with unspecified outcomes, physical therapy, home exercise program, acupuncture and medications. There is continued back pain, but no progression noted of signs or symptoms. The MTUS ACOEM notes that electrodiagnostic studies may be used when the neurologic examination is unclear, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. In this case, there was not a neurologic exam showing equivocal signs that might warrant clarification with electrodiagnostic testing, or no progression or worsening of such signs. The request is not medically necessary.