

Case Number:	CM15-0160302		
Date Assigned:	08/26/2015	Date of Injury:	11/24/2014
Decision Date:	10/14/2015	UR Denial Date:	07/31/2015
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: Illinois, California, Texas

Certification(s)/Specialty: Orthopedic Surgery

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This injured worker is a 45-year-old male who sustained an industrial injury on 11/24/14. Injury occurred when he slipped and fell, landing on his low back. Past medical history was positive for hypertension. Social history was positive for smoking 15 cigarettes a day. Conservative treatment included physical therapy, activity modification, bracing, injections, and medications. The 2/3/15 lumbar spine MRI demonstrated a 4 mm broad-based disc bulge at L5/S1, unroofing inferiorly extending into both foramina. There was 1 mm retrolisthesis at L5/S1, moderate to severe disc degeneration, and reactive marrow edema. There was mild to moderate bilateral foraminal stenosis at L5/S1. The 2/3/15 cervical spine MRI impression documented 1 mm central disc protrusions at C3/4 and C4/5, and 3 mm broad-based disc bulge with bilateral uncovertebral osteophytes at C5/6. There was a small central extrusion migrating 3 mm below the C6 superior endplate. There was mild cord flattening centrally and moderate bilateral foraminal stenosis and disc desiccation at this level with endplate irregularity. At C6/7, there was a 4 mm broad-based disc protrusion, mild to moderate spinal cord flattening and bilateral moderate foraminal stenosis. There was a reversal of the lordosis and 10% anterior wedging of C5/6. The 7/16/15 treating physician report cited intermittent moderate and occasionally severe neck pain, located at the base of the head and neck, extending to the upper back between the shoulder blades. He also reported pain radiating into the left upper extremity to the hand with numbness and tingling. Lumbar spine complaints included constant low back pain radiating to the right lower extremity to the foot with pins and needles in both feet. He had increased pain with bending, and prolonged sitting and standing. He had difficulty sleeping and woke with pain and discomfort. He reported bowel and bladder urgency. Physical exam documented mild to moderate loss of cervical range of motion, bilateral trapezius muscle spasms, and pain with

extension. Spurling's was negative bilaterally, and there was left grip strength weakness. Neurologic exam documented 5/5 upper extremity strength, decreased left C6 and C7 sensation, and diminished left upper extremity reflexes. Mid-biceps girth was 30 cm right and 29 cm left; mid-forearm girth was 27.5 cm right and 26 cm left. Lumbar spine exam documented antalgic posture on the left with wide stance, difficulty rising from a chair, and extremely guarded movement. There was restricted lumbar range of motion, difficulty in left heel/toe walk, paraspinal spasms, and L5/S1 facet tenderness. Lower extremity neurologic exam documented 5-/5 right L5 and S1 myotomal weakness, decreased right S1 sensation, and normal deep tendon reflexes. Imaging was reviewed. The treatment plan included anterior lumbar interbody fusion at L5/S1 with associated surgical services, including bilateral upper and lower extremity EMG/nerve conduction study was recommended to rule-out radiculopathy and nerve compression. Authorization was requested for pre-operative bilateral upper extremity EMG/NCV. The 7/31/15 utilization review certified requests for anterior lumbar interbody fusion at L5/S1, 3-day inpatient stay, assistant surgeon, thoracolumbosacral orthosis, pre-operative lower extremity EMG/NCV, and neurologist, urologist and psychologist evaluations. The request for pre-operative EMG/NCV was non-certified as these studies were not medically necessary and the treating physician agreed to non-certification.

IMR ISSUES, DECISIONS AND RATIONALES

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

Associated surgical services: Pre-op EMG/NCV bilateral upper extremities: Overturned

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Diagnostic Criteria.

Decision rationale: The California MTUS ACOEM guidelines state that EMG/NCV may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than 3 to 4 weeks, and may include sensory-evoked potentials if spinal stenosis or spinal cord myelopathy is suspected. Guideline criteria have been met. This injured worker presents with neck pain radiating into the left upper extremity to the hand with numbness and tingling. Clinical exam is consistent with neural compression. There is imaging evidence of multilevel disc disease and cord flattening. Therefore, this request is medically necessary.