MAXIMUS Federal Services

Case Number:	CM15-0190610		
Date Assigned:	10/02/2015	Date of Injury:	12/23/1997
Decision Date:	11/18/2015	UR Denial Date:	09/08/2015
Priority:	Standard	Application Received:	09/28/2015

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
Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 with a date of injury on 12-23-1997. The injured worker is undergoing treatment for post lumbar fusion and lumbar radiculitis. In a note dated 07-17-2015 documents the injured worker complains of lower back pain that he rates a 6-7 out of 10 on the Visual Analog Scale with medications and 8 out of 10 without meds. He has pain in the bottom of both feet that her rates as 6 out of 10 with medications and 8 out of 10 without medications. There is positive S1 joint provocative testing, thigh thrust bilaterally, Fortin sign and compression sign. A physician progress note dated 08-18-2015 documents the injured worker complains of low back pain that radiates into the buttocks, hip, foot and toes. Symptoms include tingling, burning pain, stabbing pain and numbness. He rates his pain as 8 out of 10 on the pain scale. His symptoms are worsening. Symptoms are improved with the use of heat, ice and medications. On examination, there are spasms, and decreased range of motion. He has a positive straight leg raise. Treatment to date has included diagnostic studies, medications, status post lumbar fusion, epidural injections, and multiple radiofrequency ablations. Current medications include Flexeril, Soma, Percocet, and Norco. X ray of the lumbar spine shows anterior cages, L5-S1. An Magnetic Resonance Imaging of the lumbar spine done on 10-17-2013 and reviewed on 12-16-2013 shows post-surgical changes at L5-S1 with disc spacer level fusion and laminectomy defect with scar type changes in the left subarticular zone contributing to moderate left sided foraminal and left sided subarticular zone stenosis, and mild right sided foraminal narrowing is present. There is moderate right and mild to moderate left sided foraminal narrowing at L4-5 due to disc level degenerative changes, ligamentum flavum

buckling and bilateral reactive facet arthropathy. The treatment plan includes a CT scan of the lumbar spine, EMG/NCV of right left lower extremities, and a follow up with chronic pain management. On 09-08-2015 Utilization Review non-certified, the request for CT scan of the lumbar spine and EMG/NCV of right left lower extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

CT scan of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

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 chapter under Computed Tomography (CT scan).

Decision rationale: The patient was injured on 12/23/97 and presents with back pain which radiates to the buttock, hip, foot, and toes. The request is for CT SCAN OF THE LUMBAR SPINE. There is no RFA provided and the patient is temporarily very disabled. Review of the reports provided does not indicate if the patient had a prior CT scan of the lumbar spine. ODG guidelines, low back chapter under Computed Tomography (CT scan) states: "Not recommended except for indications below for CT. Magnetic resonance imaging has largely replaced computed tomography scanning in the noninvasive evaluation of patients with painful myelopathy because of superior soft tissue resolution and multiplanar capability." Indications for imaging: Thoracic spine trauma: equivocal or positive plain films, no neurological deficit; Thoracic spine trauma: with neurological deficit; Lumbar spine trauma: trauma, neurological deficit; Lumbar spine trauma: seat belt, chance-fracture; Myelopathy; neurological deficit related to the spinal cord, traumatic; Myelopathy, infectious disease patient; Evaluate pars defect not identified on plain x-rays; Evaluate successful fusion if plain x-rays do not confirm fusion. The patient has spasms along his back, a limited lumbar spine range of motion, and a positive straight leg raise. He is diagnosed with post lumbar fusion and lumbar radiculitis. Treatment to date includes diagnostic studies, medications, status post lumbar fusion, epidural injections, and multiple radiofrequency ablations. The reason for the request is not provided. The 10/17/13 MRI of the lumbar spine revealed post-surgical changes at L5-S1 with disc spacer level fusion and laminectomy defect with scar type changes in the left subarticular zone contributing to moderate left sided foraminal and left sided subarticular zone stenosis, and mild right sided foraminal narrowing is present. There is moderate right and mild to moderate left sided foraminal narrowing at L4-5 due to disc level degenerative changes, ligamentum flavum buckling and bilateral reactive facet arthropathy. X ray of the lumbar spine shows anterior cages, L5-S1 (date of x-ray not provided). ODG does not recommend CT scan of the lumbar spine unless there is lumbar spine trauma with neurologic deficit, or seat belt trauma with chance of fracture. There is no documentation that patient presents with aforementioned indications. Furthermore, the patient underwent a recent MRI of the lumbar spine and the treater does not explain why a CT is needed. The patient does have a history of lumbar fusion but the X-ray provided does not indicate any concern regarding

pseudarthrosis for which a CT scan may be indicated. Therefore, the request IS NOT medically necessary.

EMG/NCV of right left lower extremities: Overturned

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back chapter, under EMGs Back chapter, under Nerve conduction studies.

Decision rationale: The patient was injured on 12/23/97 and presents with back pain which radiates to the buttock, hip, foot, and toes. The request is for an EMG/NCV OF RIGHT LEFT LOWER EXTREMITIES. The utilization review rationale is that “despite positive exam findings, the injury is nearly 18 years ago and there is no indication if there has been previous electrodiagnostic test and/or what symptoms have worsened and/or changed the warrant this test.” There is no RFA provided and the patient is temporarily totally disabled. Review of the reports provided does not indicate if the patient had a prior EMG/NCV of the lower extremities. MTUS/ACOEM Guidelines Chapter 12 Low Back Complaints, page 303 on Special Studies and Diagnostic and Treatment Considerations states, “Electromyography, including H- reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks." ODG guidelines under foot/ankle chapter does not discuss electrodiagnostics. ODG Guidelines, Low Back chapter, under EMGs, electromyography, ODG states, “Recommended as an option needle, not surface. EMGs may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious." ODG Guidelines, Low Back chapter, under Nerve conduction studies, NCS, states, “Not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy.” ODG for Electrodiagnositic studies states, “NCS which are not recommended for low back conditions, and EMGs which are recommended as an option for low back.” The patient has spasms along his back, a limited lumbar spine range of motion, and a positive straight leg raise. He is diagnosed with post lumbar fusion and lumbar radiculitis. Treatment to date includes diagnostic studies, medications, status post lumbar fusion, epidural injections, and multiple radiofrequency ablations. The reason for the request is not provided. The 10/17/13 MRI of the lumbar spine revealed post-surgical changes at L5-S1 with disc spacer level fusion and laminectomy defect with scar type changes in the left subarticular zone contributing to moderate left sided foraminal and left sided subarticular zone stenosis, and mild right sided foraminal narrowing is present. There is moderate right and mild to moderate left sided foraminal narrowing at L4-5 due to disc level degenerative changes, ligamentum flavum buckling and bilateral reactive facet arthropathy. X ray of the lumbar spine shows anterior cages, L5-S1 (date of x-ray not provided). Due to the patient’s increase in pain, the request appears reasonable. The requested EMG/NCV of the lower extremities IS medically necessary.