

<b>Case Number:</b>	CM15-0203248		
<b>Date Assigned:</b>	10/19/2015	<b>Date of Injury:</b>	11/18/2014
<b>Decision Date:</b>	12/03/2015	<b>UR Denial Date:</b>	09/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/16/2015

### 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, California  
 Certification(s)/Specialty: Family Practice

### 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 is a 63 year old male patient, who sustained an industrial injury on 11-18-14. The diagnoses have included sprain of neck; sprain of lumbar; thoracic or lumbosacral neuritis or radiculitis, unspecified; bilateral knee patella femoral arthritis and bilateral ankle sprain. Per the doctor's note dated 9/3/15, he had complaints of low back pain and right lower extremity pain with numbness and tingling to big toe. He pain at 7 to 8 out of 10 on the pain scale. The physical examination of the lumbar spine revealed tenderness, spasm, decreased range of motion, positive straight leg raising test over the right foot in L5 distribution and decreased sensation in right L5 dermatome. The current medications list is not specified in the records provided. He had lumbar spine X-ray which revealed disc disease at L3, L4, L4-L5 and L5-S1 (sacroiliac), short pedicles throughout, no spondylolisthesis, no fractures and no dislocations; magnetic resonance imaging (MRI) which revealed disc disease at L3-L4, L4-L5 and L5-S1 (sacroiliac), at L4-L5 and L5-S1 (sacroiliac), disc bulges centrally and severe foraminal stenosis bilaterally at L4-L5 and L5-S1 (sacroiliac). Treatment to date has included chiropractic sessions. The original utilization review (9-22-15) non-certified the request for magnetic resonance imaging (MRI) of the lumbar spine and electromyography and nerve conduction velocity study of the right lower extremity. Several documents within the submitted medical records are difficult to decipher.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **MRI lumbar spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines; Work Loss Data Institute, LLC; Corpus Christi, TX; www.odg-twc.com; Section: Low Back - Lumbar & Thoracic (Acute & Chronic), MRI, updated (update 7/17/2015).

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter: Low Back (updated 09/22/15) MRIs (magnetic resonance imaging).

**Decision rationale:** MRI lumbar spine. Per the ACOEM low back guidelines unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures). The records provided do not specify any progression of neurological deficits for this patient. Per the records provided the patient had lumbar spine X-ray which revealed disc disease at L3, L4, L4-L5 and L5-S1 (sacroiliac), short pedicles throughout, no spondylolisthesis, no fractures and no dislocations; magnetic resonance imaging (MRI) which revealed disc disease at L3-L4, L4-L5 and L5-S1 (sacroiliac), at L4-L5 and L5-S1 (sacroiliac), disc bulges centrally and severe foraminal stenosis bilaterally at L4-L5 and L5-S1 (sacroiliac). Per the cited guidelines Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation). A significant change in the patient's condition since the last MRI that would require a repeat lumbar MRI is not specified in the records provided. Response to recent conservative therapy is not specified in the records provided. An electrodiagnostic study has also been requested by the treating doctor. The result of that study is pending. The medical necessity of MRI lumbar spine is not fully established for this patient at this juncture, therefore is not medically necessary.

## **Electromyography (EMG)/nerve conduction velocity (NCV) right lower extremity: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines; Work Loss Data Institute, LLC; Corpus Christi, TX; www.odg-twc.com; Section: Low Back - Lumbar & Thoracic (Acute & Chronic), electrodiagnostic studies, (updated 7/17/2015).

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

**Decision rationale:** Electromyography (EMG)/nerve conduction velocity (NCV) right lower extremity. Per ACOEM guidelines, Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. Per the records provided the patient has low back pain and right lower extremity pain with numbness and tingling to big toe. The patient has neurological findings in the right lower extremity- tenderness, spasm, decreased range of motion, positive straight leg raising test over the right foot in L5 distribution and decreased sensation in right L5 dermatome. It is medically necessary and appropriate to do an EMG/ NCS of the right lower extremity to diagnose lumbar radiculopathy and to evaluate the extent of involvement of the affected nerves as this will guide further management. The request of Electromyography (EMG)/nerve conduction velocity (NCV) right lower extremity is medically necessary and appropriate for this patient at this time.