

Case Number:	CM15-0203280		
Date Assigned:	10/20/2015	Date of Injury:	06/22/2015
Decision Date:	12/07/2015	UR Denial Date:	09/24/2015
Priority:	Standard	Application Received:	10/15/2015

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 [REDACTED] who has filed a claim for low back pain (LBP) reportedly associated with an industrial injury of June 26, 2015. In a Utilization Review report dated December 24, 2015, the claims administrator failed to approve requests for electrodiagnostic testing of bilateral lower extremities and an L5-S1 selective nerve root block. The claims administrator referenced an RFA form received on September 21, 2015 in its determination. The applicant personally appealed via a fax dated October 15, 2015. On an RFA form dated September 18, 2015, electrodiagnostic studies of bilateral lower extremities, an L5-S1 selective nerve block, diclofenac, Valium, and Neurontin were all endorsed. On an associated progress note dated September 15, 2015, the applicant reported ongoing complaints of low back pain, radiating to the left lower extremity. 6-8/10 pain complaints were reported. The attending provider then stated in another section of note, that the applicant had occasional numbness about the bilateral feet and legs. The physical therapy had not proven beneficial, the treating provider acknowledged. The applicant had no significant past medical history, the treating provider acknowledged. Hyposensorium about the legs was reported with well-persevered, 5/5 lower extremity motor function. The applicant also exhibited myofascial tenderness and positive facet loading, the treating provider reported. Multiple medications, including diclofenac, Neurontin, and Valium were endorsed while the selective nerve root blocks and medial branch blocks were sought. The applicant was placed off of work, on total temporary disability. Electrodiagnostic testing of bilateral lower extremities was also sought. The attending provider stated that the MRI imaging of the lumbar spine was pending. Lumbar MRI imaging dated July 30, 2015 was notable for neuroforaminal stenosis at L5-S1 and a far lateral disk osteophyte complex at L3-4 generating left exiting L3 nerve root impingement.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electromyograph (EMG) and nerve conduction studies (NCS) of bilateral lower extremities: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Summary, and Ankle and Foot Complaints 2004, Section(s): Summary.

Decision rationale: No, the request for electrodiagnostic testing (EMG-NCS) of the bilateral lower extremities was not medically necessary, medically appropriate, or indicated here. As noted in the MTUS Guideline in ACOEM Chapter 12, Table 12-8, page 300, EMG testing is deemed not recommended for applicants who carry a diagnosis of clinical obvious radiculopathy. In a similar vein, the MTUS Guideline in ACOEM Chapter 14, Table 14-6, page 377, also notes that electrical studies (AKA nerve conduction testing) are not recommended without some clinical evidence of tarsal tunnel syndrome or other entrapment neuropathy. Here, however, lumbar radiculopathy appears to represent the sole item on the differential diagnosis list, per the attending provider's September 15, 2015 office visit. There was no mention of the applicant's having a suspected tarsal tunnel syndrome or focal entrapment neuropathy. There was no mention of the applicant's having systemic disease process such as diabetes, alcoholism, hypothyroidism, hepatitis, etc., which would have heightened the applicant's predisposition toward development of generalized peripheral neuropathy. It was not clearly stated why electrodiagnostic testing was sought when the applicant already had an established diagnosis of clinically evident, radiographically confirmed lumbar radiculopathy at L3-L4, per MRI imaging of July 30, 2015. Therefore, the request was not medically necessary.

Bilateral L5-S1 selective nerve root block: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: Similarly, the request for an L5-S1 selective nerve root block (AKA) lumbar epidural steroid injection was not medically necessary, medically appropriate, or indicated here. While the MTUS Guideline in ACOEM Chapter 12, page 12-8, page 309 acknowledges that epidural steroid injections are deemed optional for radicular pain, to avoid surgery, here, however, the attending provider's September 15, 2015 office visit failed to clearly state or clearly identify why the L5-S1 level was being targeted when the applicant's most prominent radiographic findings, per lumbar MRI imaging of July 30, 2015, were at the L3-L4

level. The applicant was described as having an L3-L4 disk osteophyte complex and an associated left exiting L3 nerve root impingement. The L5-S1 level targeted did not appear to have significant changes noted on said lumbar MRI. The attending provider failed to state why he had selected this particular level to inject. The attending provider's September 15, 2015 office visit seemingly suggested that the attending provider had not reviewed the results of earlier lumbar MRI imaging dated July 30, 2015. The attending provider failed to furnish a clear rationale for his decision to target the L5-S1 level, i.e., level at which there was not much structural evidence of radiculopathy. Therefore, the request was not medically necessary.