

Case Number:	CM15-0029023		
Date Assigned:	02/23/2015	Date of Injury:	11/18/2009
Decision Date:	04/21/2015	UR Denial Date:	01/20/2015
Priority:	Standard	Application Received:	02/17/2015

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: 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 54 year old female, who sustained an industrial injury on November 18, 2009. She reported low back pain radiating into her right lower extremity and right thigh numbness. The injured worker was diagnosed as having myofascial pain of the cervical spine, cervical spine degenerative disc disease, and cervical radiculopathy. Treatment to date has included MRI in 2013, work modifications, lumbar support, ice/heat, physical therapy, home exercise program, serial lumbar epidural steroid injections, non-steroidal anti-inflammatory and steroid injections, and medications including pain, muscle relaxant, and non-steroidal anti-inflammatory. On June 16, 2014, the qualified medical evaluator reports the injured worker complains of constant, right-sided low back pain. The pain is stabbing and aching with bilateral buttocks and bilateral lower extremities pain. She reports having fallen due to right lower extremity weakness a couple of times. Her back symptoms increase with coughing, sneezing, and bowel movement. She has difficulty going upstairs due to right lower extremity weakness, and has had more than one episode of loss of urinary/bowel control. The physical exam revealed slight tenderness to palpation of lumbar 4-5 and no tenderness to palpation of the dorsal spine, the sacroiliac joints, hip joints or sciatic notch areas. She was able to heel walks, toe walks, and squats without difficulty, and complains of back pain with squatting. There was moderately decreased flexion, mildly decreased extension and mildly decreased lateral bending bilaterally with pain. The right supine straight leg raise was positive at 50 degrees and the sitting straight leg raise were negative bilaterally. The deep tendon reflexes and motor functions were normal.

There was mildly decreased sensation in the right lower extremity. X-rays of the cervical spine were during this visit.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI (magnetic resonance imaging) 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, MRIs (magnetic resonance imaging).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178. Decision based on Non-MTUS Citation Official disability guidelines Low back chapter, MRI.

Decision rationale: Based on the 06/16/14 QME report provided by treating physician, the patient presents with low back pain that radiates to the bilateral extremities. The request is for MRI (MAGNETIC RESONANCE IMAGING) OF THE LUMBAR SPINE. RFA not provided. Patient's diagnosis per QME report dated 06/16/14 included lumbar spine myofascial sprain, rule out lumbar radiculopathy. Examination to the lumbar spine on 06/16/14 revealed decreased sensation in the right lower extremity, pain with range of motion and positive straight leg raise test on the right. Treatment to date has included MRI in 2013, work modifications, lumbar support, ice/heat, physical therapy, home exercise program, serial lumbar epidural steroid injections, non-steroidal anti-inflammatory and steroid injections, and medications including pain, muscle relaxant, and non-steroidal anti-inflammatory. Per [REDACTED] industrial work status report dated 06/30/14, the patient has permanent modified restrictions. ACOEM Guidelines, chapter 8, page 177 and 178, state: Unequivocal objective findings that identify specific nerve compromise on the neurological examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. ODG Guidelines do not support MRIs unless there are neurologic signs/symptoms present. Repeat MRI's are indicated only if there has been progression of neurologic deficit." ODG guidelines, Low back chapter, MRIs (magnetic resonance imaging) (L-spine) state that "for uncomplicated back pain MRIs are recommended for radiculopathy following at least one month of conservative treatment." ODG guidelines further state the following regarding MRI's, Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation). Per QME report dated 06/16/14, examiner states "EMG and Nerve Conduction Velocity Studies of the cervical spine and both upper extremities, along with lumbar spine and both lower extremities should be done, along with MRI study of the cervical spine. If a new lumbar spine MRI study has been done, it should be obtained for my review." MRI of the lumbar spine on 07/09/14 revealed "L3-L4: there is loss of disk signal with end plate osteophyte formation and a far left lateral intraforaminal 3mm protrusion with annular fissure resulting in moderate left foraminal stenosis. L4-L5: there is loss of disk signal without focal abnormalities. There is bilateral facet arthropathy. L5-S1: there is loss of disk signal with left intraforaminal 2mm protrusion resulting in moderate left foraminal stenosis." Progress report

with the request was not provided. According to guidelines, for an updated or repeat MRI, the patient must be post-operative or present with a new injury, red flags such as infection, tumor, fracture or neurologic progression. This patient does not present with any of these. Therefore, the request IS NOT medically necessary.

EMG (electromyography)/NCV (nerve conduction velocity) of the bilateral lower extremities: 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), EMG (electromyography); NCS (nerve conduction study).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official disability guidelines Low Back Chapter, under Nerve conduction studies & Electrodiagnostic studies (EDS).

Decision rationale: Based on the 06/16/14 QME report provided by treating physician, the patient presents with low back pain that radiates to the bilateral extremities. The request is for EMG (ELECTROMYOGRAPHY)/NCV (NERVE CONDUCTION VELOCITY) OF THE BILATERAL LOWER EXTREMITIES. RFA not provided. Patient's diagnosis per QME report dated 06/16/14 included lumbar spine myofascial sprain, rule out lumbar radiculopathy. Examination to the lumbar spine on 06/16/14 revealed decreased sensation in the right lower extremity, pain with range of motion and positive straight leg raise test on the right. Treatment to date has included MRI in 2013, work modifications, lumbar support, ice/heat, physical therapy, home exercise program, serial lumbar epidural steroid injections, non-steroidal anti-inflammatory and steroid injections, and medications including pain, muscle relaxant, and non-steroidal anti-inflammatory. Per [REDACTED] industrial work status report dated 06/30/14, the patient has permanent modified restrictions. For EMG, ACOEM Guidelines page 303 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." Regarding Nerve conduction studies, ODG guidelines Low Back Chapter, under Nerve conduction studies 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 Electrodiagnostic studies (EDS) states: (NCS) which are not recommended for low back conditions and EMGs (Electromyography) which are recommended as an option for low back. Per QME report dated 06/16/14, examiner states "EMG and Nerve Conduction Velocity Studies of the cervical spine and both upper extremities, along with lumbar spine and both lower extremities should be done, along with MRI study of the cervical spine. If a new lumbar spine MRI study has been done, it should be obtained for my review." Progress report with the request was not provided. UR letter dated 01/20/15 states "Electrodiagnostic Study Results dated 10/14/14 documented abnormal electrodiagnostic studies of the bilateral lower extremities consistent with a bilateral chronic L5 radiculopathy. There was no evidence of peripheral neuropathy." There is no explanation as to why a repeat study is needed, and there has not been any change in the patient's clinical presentation. Therefore, the request IS NOT medically necessary.