

Case Number:	CM15-0220588		
Date Assigned:	11/13/2015	Date of Injury:	12/15/2011
Decision Date:	12/23/2015	UR Denial Date:	10/19/2015
Priority:	Standard	Application Received:	11/09/2015

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, Indiana, New York
 Certification(s)/Specialty: Internal 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 injured worker is a 39-year-old male, who sustained an industrial injury on 12-15-11. The injured worker was diagnosed as having lumbar discopathy; lumbar stenosis; sciatica; status post lumbar decompressive laminectomy of central stenosis-removal of epidural lipomatosis-ligamentous hypertrophy (12-15-11). Treatment to date has included medications. Currently, the PR-2 notes dated 8-18-15 indicated the injured worker was seen for an orthopedic re-evaluation. The injured worker is complaining of constant severe pain in the low back that is aggravated by bending, lifting, twisting, pushing, pulling, prolonged sitting, standing, walking and is characterized as sharp. There is radiation to the lower extremities with numbness and tingling reported by the injured worker. The pain is worsening and the provider notes, "On a scale of 1 to 10, the pain is a 9." The provider notes the pain is increasing and his nighttime pain and paresthesia that wakens him and he is having difficulty with activities of daily living. The provider documents a physical examination and notes the injured worker's gait is normal. He notes a well-healed scar in the midline of his lumbar spine. He has palpable paravertebral muscle tenderness and spasm. His range of motion is noted as guarded and restricted. He has radiating pain with diminished sensation in the lateral thigh, anterolateral and posterior leg as well as foot, consistent with an L5 and S1 dermatomal pattern. There is 4 strength in the EHL and ankle plantar flexors, L5 and S1 innervated muscles. The provider's treatment plan indicates the injured workers pain is worsening and his condition is deteriorating due to pain and bilateral radiculopathy. He is requesting updated diagnostics to assess his pathology. The medical documentation submitted did not contain reports of MRI or x-rays of the lumbar spine since 2011. A Request for Authorization is dated 11-2-15. A Utilization Review letter is dated 10-19-15 and

non-certification for MRI Lumbar Spine Open Protocol-Stand-Up and EMG-NCV Bilateral Lower Extremities. A request for authorization has been received for MRI Lumbar Spine Open Protocol-Stand-Up and EMG-NCV Bilateral Lower Extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI Lumbar Spine Open Protocol/Stand-Up: 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).

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 section, MRI lumbar spine.

Decision rationale: Pursuant to the Official Disability Guidelines, MRI of the lumbar spine (open protocol/stand-up) is not medically necessary. MRIs of the test of choice in patients with prior back surgery, but for uncomplicated low back pain, with radiculopathy, it is not recommended until after at least one month conservative therapy, sooner if severe or progressive neurologic deficit. Repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and findings suggestive of significant pathology. Indications (enumerated in the official disability guidelines) for imaging include, but are not limited to, lumbar spine trauma, neurologic deficit; uncomplicated low back pain with red flag; uncomplicated low back pain prior lumbar surgery; etc. ACOEM states unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients not respond to treatment and who would consider surgery an option. See the ODG for details. In this case, the injured worker's working diagnoses are lumbar discopathy; and status post lumbar laminectomy. Date of injury is December 15, 2011. Request for authorization is October 12, 2015. Documentation indicates the injured worker had an MRI lumbar spine on two occasions dated August 5, 2011 and December 25, 2011. The latter date showed generative changes. According to an August 18, 2015 progress note, subjective complaints include low back pain that radiates to the lower extremities with numbness and tingling with the pain score 9/10. Objectively, there is tenderness to palpation with decreased range of motion of the lumbar spine. There is no evidence of instability. Sensation is decreased at the L5 - S1 dermatome. There are no significant changes in subjective symptoms or objective clinical findings documented in the medical record suggestive of significant pathology. There are no unequivocal objective findings that identify specific nerve compromise on the neurologic examination. There is no clinical rationale for an open protocol standup MRI. Based on the clinical information in the medical record, peer-reviewed evidence-based guidelines, no unequivocal objective neurologic findings and no significant changes in subjective symptoms and objective clinical findings, MRI of the lumbar spine (open protocol/stand-up) is not medically necessary.

EMG/NCV Bilateral Lower Extremities: Upheld

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 section, EMG/NCV.

Decision rationale: Pursuant to the ACOEM and Official Disability Guidelines, EMG/NCV bilateral lower extremities are not medically necessary. Nerve conduction studies are not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms based on radiculopathy. EMGs may be useful to obtain unequivocal evidence of radiculopathy, after one-month conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious. The ACOEM states unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging if symptoms persist. In this case, the injured worker's working diagnoses are lumbar discopathy; and status post lumbar laminectomy. Date of injury is December 15, 2011. Request for authorization is October 12, 2015. Documentation indicates the injured worker had an MRI lumbar spine on two occasions dated August 5, 2011 and December 25, 2011. The latter date showed generative changes. According to an August 18, 2015 progress note, subjective complaints include low back pain that radiates to the lower extremities with numbness and tingling with the pain score 9/10. Objectively, there is tenderness to palpation with decreased range of motion of the lumbar spine. There is no evidence of instability. Sensation is decreased at the L5 - S1 dermatome. There are no significant changes in subjective symptoms or objective clinical findings documented in the medical record suggestive of significant pathology. There are no unequivocal objective findings that identify specific nerve compromise on the neurologic examination. The treatment plan indicates the treating provider wants to update electrodiagnostic studies based on the progression/increase of the injured workers symptoms. The original electrodiagnostic study (hard copy) is not present in the medical record review. In the absence of the original electrodiagnostic study, a subsequent electrodiagnostic study is not clinically indicated. Based on clinical information in the medical record, peer-reviewed evidence-based guidelines and no hardcopy documentation of the original electrodiagnostic study, EMG/NCV bilateral lower extremities are not medically necessary.