

Case Number:	CM15-0055469		
Date Assigned:	03/30/2015	Date of Injury:	03/27/2013
Decision Date:	05/04/2015	UR Denial Date:	02/25/2015
Priority:	Standard	Application Received:	03/23/2015

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 39 year old male, who sustained an industrial injury on 3/27/13. He has reported an injury after a bunch of mattresses fell on him. The diagnoses have included lumbar spine strain, degenerative disc disease (DDD), and chronic back and leg pain. Treatment to date has included diagnostics, medications, pain management, and 2 lumbar Epidural Steroid Injections (ESI). The Magnetic Resonance Imaging (MRI) of the lumbar spine revealed disc degeneration at two levels. The x-rays were done on 2/24/15. The current medications included Norco, Flexeril, Gabapentin and Valium. Currently, as per the Doctor's First Report dated 2/17/15, the injured worker complains of ongoing pain in the back that radiates to the left leg. He has not been doing a Home Exercise Program (HEP). The physical exam revealed range of motion of the lumbar spine is 50 percent normal, extension causes pain that radiates to the buttocks left greater than right, and diffuse weakness with numbness was noted in the left leg. It was noted that after the second Epidural Steroid Injection (ESI) was given he began having left leg pain and it is possible that he has developed some scar tissue from bleeding from the epidural. The physician requested treatments included Medial branch blocks at L4-5, EMG of the lower extremities and NCS of the lower extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

Medial branch blocks at L4-5: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation low back chapter, diagnostic facet blocks.

Decision rationale: The patient was injured on 03/27/13 and presents with pain in his back, bilateral shoulders, bilateral upper extremities, bilateral lower extremities, bilateral feet, and ribs. The request is for a medial branch block at L4-5. The utilization review letter did not provide a rationale. There is no RFA provided and the patient can return to modified work on 02/17/15. Review of the reports provided does not indicate if the patient had a prior medial branch block. The ACOEM Guidelines do not support facet injections for treatment but does discuss dorsal medial branch blocks as well as radiofrequency ablations. ODG Guidelines also support facet diagnostic evaluations for patients presenting with paravertebral tenderness with non-radicular symptoms. No more than 2 levels bilaterally are recommended. The 02/17/15 report states that "there is definitely increased stress at L4-5 because of the sacralization at L5-S1." There is diffuse tenderness to palpation over the lumbar paraspinal muscle and moderate facet tenderness to palpation at L3 through S1. He has a positive Kemp's test on both the right and left side. His range of motion of the lumbar spine is 50 percent normal, extension causes pain that radiates to the buttocks left greater than right, and diffuse weakness with numbness was noted in the left leg. It was noted that after the second Epidural Steroid Injection (ESI) was given he began having left leg pain. The treater has asked for EMG/NCV studies to investigate the patient's leg symptoms. ODG does not support facet evaluations when radicular symptoms or sensory findings are noted on exam. The request IS NOT medically necessary.

EMG of the lower extremities: Overturned

Claims Administrator 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.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

Decision rationale: The patient was injured on 03/27/13 and presents with pain in his back, bilateral shoulders, bilateral upper extremities, bilateral lower extremities, bilateral feet, and ribs. The request is for an EMG of the lower extremities "to document whether there is indeed radiculopathy." The utilization review letter did not provide a rationale. There is no RFA provided and the patient can return to modified work on 02/17/15. Review of the reports provided does not indicate if the patient had a prior EMG of the lower extremities. For EMG, ACOEM Guidelines page 303 states, "Electromyography including H-reflex test may be useful to identify subtle, focal neurologic dysfunction, patient with low back pain lasting more than 3 or 4 weeks." The 02/17/15 report states that "there is definitely increased stress at L4-5 because of the sacralization at L5-S1." There is diffuse tenderness to palpation over the lumbar paraspinal

muscle and moderate facet tenderness to palpation at L3 through S1. He has a positive Kemp's test on both the right and left side. His range of motion of the lumbar spine is 50 percent normal, extension causes pain that radiates to the buttocks left greater than right, and diffuse weakness with numbness was noted in the left leg. It was noted that after the second Epidural Steroid Injection (ESI) was given he began having left leg pain. The patient is diagnosed with lumbar spine disc disease, lumbar spine radiculopathy, lumbar spine facet syndrome, and status post rib fracture. There is no indication of any prior EMG of the lower extremities. In this case, the patient has had low back pain since at least 09/25/14. Given the persistent chronic pain, an EMG of the left lower extremities appears reasonable. Therefore, the request IS medically necessary.

NCS of the lower extremities: Upheld

Claims Administrator 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.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Low back chapter, NCV studies.

Decision rationale: The patient was injured on 03/27/13 and presents with pain in his back, bilateral shoulders, bilateral upper extremities, bilateral lower extremities, bilateral feet, and ribs. The request is for an EMG of the lower extremities "to document whether there is indeed radiculopathy." The utilization review letter did not provide a rationale. There is no RFA provided and the patient can return to modified work on 02/17/15. Review of the reports provided does not indicate if the patient had a prior EMG of the lower extremities. For EMG, ACOEM Guidelines page 303 states, "Electromyography including H-reflex test may be useful to identify subtle, focal neurologic dysfunction, patient with low back pain lasting more than 3 or 4 weeks." The 02/17/15 report states that "there is definitely increased stress at L4-5 because of the sacralization at L5-S1." There is diffuse tenderness to palpation over the lumbar paraspinal muscle and moderate facet tenderness to palpation at L3 through S1. He has a positive Kemp's test on both the right and left side. His range of motion of the lumbar spine is 50 percent normal, extension causes pain that radiates to the buttocks left greater than right, and diffuse weakness with numbness was noted in the left leg. It was noted that after the second Epidural Steroid Injection (ESI) was given he began having left leg pain. The patient is diagnosed with lumbar spine disc disease, lumbar spine radiculopathy, lumbar spine facet syndrome, and status post rib fracture. There is no indication of any prior EMG of the lower extremities. In this case, the patient has had low back pain since at least 09/25/14. Given the persistent chronic pain, an EMG of the left lower extremities appears reasonable. Therefore, the request IS medically necessary.