

Case Number:	CM15-0087282		
Date Assigned:	05/11/2015	Date of Injury:	01/14/2014
Decision Date:	06/16/2015	UR Denial Date:	04/15/2015
Priority:	Standard	Application Received:	05/06/2015

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: 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 injured worker is a 53 year old female, who sustained an industrial injury on 1/14/14. The injured worker has complaints of low back pain that radiates down to both buttocks and down the left leg. The diagnoses have included spinal stenosis and collapsing disc. Treatment to date has included lumbar spine X-rays on 3/31/15 showed a significant buckling down of L5 on S1 (sacroiliac) on the left side, on lateral view there was significant collapse of disc space at L5-S1 (sacroiliac) with foraminal narrowing; mobic; nortriptyline and protonix. The request was for dynamic Stand-up magnetic resonance imaging (MRI) lumbar spine and electromyography/nerve conduction velocity bilateral lower extremity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Dynamic Stand-up MRI lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 297, 303, 304, 309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter/MRI (Magnetic Resonance Imaging) Section.

Decision rationale: The MTUS Guidelines do not recommend the routine use of MRI with low back complaints. MRI should be reserved for cases where there is physiologic evidence that tissue insult or nerve impairment exists, and the MRI is used to determine the specific cause. MRI is recommended if there is concern for spinal stenosis, cauda equine, tumor, infection or fracture is strongly suspected, and x-rays are negative. The ODG recommends repeat MRI when there is significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation). There has been no change in symptoms or on examination since the previous MRI which was essentially normal. The request for dynamic stand-up MRI lumbar spine is determined to not be medically necessary.

EMG/NCV bilateral lower extremity: 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): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter/Nerve Conduction Studies (NCS) section.

Decision rationale: Per the MTUS Guidelines, EMG may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. The MTUS Guidelines do not specifically address nerve conduction studies of the lower extremities. Per the ODG, nerve conduction studies are not recommended because there is minimal justification of performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. There was subjective loss of partial sensation in the lower extremities, however, the motor, reflex, and strength exam was normal. The requesting physician does not provide explanation of why EMG/NCV would be necessary for this injured worker, who already has identified pathology. The request for EMG/NCV bilateral lower extremity is determined to not be medically necessary.