MAXIMUS Federal Services

Case Number:	CM14-0012896		
Date Assigned:	02/03/2014	Date of Injury:	01/14/2013
Decision Date:	02/07/2014	UR Denial Date:	01/10/2014
Priority:	Expedited	Application Received:	01/31/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 46-year-old male with date of injury 01/14/2013. According to the doctor's first report dated 01/31/2013, the patient was carrying a work order when a coworker operating a forklift threw some material from the forklift he was transporting. The patient made a sudden move in order to avoid getting hit and felt a sharp pain and discomfort in his low back and waist which radiated throughout his body. At that time he was diagnosed with a lumbar strain with likely herniated nucleus pulposus with right radiculitis. He had been treated by the orthopedist [redacted] for 10 months for the single diagnosis of lumbar strain. On 10/24/2013 [redacted] added the following diagnoses: 1. Rule out cervical spine herniated nucleus pulposus, with resultant headaches; 2. Thoracic spine strain; 3. Rule out bilateral shoulder internal derangement; 5. Lumbar strain, with likely herniated nucleus pulposus with slight radiculitis; 6. Bilateral knee strain; 7. Sleep disturbance, secondary to pain; 8. Psychiatric complaints of depression and anxiety; 9. Gastrointestinal complaints; 10. Chest pain with shortness of breath; 11. Sexual dysfunction; 12. Psoriasis; 13. Hypertension. Up until 10/23/2013, the patient has been undergoing conservative treatment for his low back strain which has included aqua therapy, extracorporeal shockwave therapy, and medication. He reports occasionally in the record that he has minimal improvement in his low back symptoms or his right leg pain. An MRI of the lumbar was obtained early in the claim which showed disc desiccation at L4-5 with a 4 mm central posterior disc protrusion indenting the anterior aspect of the thecal sac and a 2 mm central posterior disc protrusion at L5-S1 which is not causing any deformity of the thecal sac. According to [redacted] report 10/24/2013, "the patient complains of pain in his low back which is described as sharp and present constantly. Radiating into the legs is indicated. He has numbness and tingling in the legs. Burring in the low back is present. Radiating into the mid back is indicated. He has difficulty with showering, dressing and putting on his shoes due to low

back pain. He has difficulty with sitting, standing and walking for a prolonged period of time due to low back pain. He has difficulty with heavy lifting due to low back pain. The patient reports that he is unable to sit in a car for a prolonged period of time due to pain. He has difficulty with sleeping due to the back pain. He is awakened by back pain. The pain in the low back is rated as an 8-9, on a scale from 1-10, 10 being the worst." There is no mention of the pain radiating to any particular dermatome of the lower extremities. The physical exam revealed that sciatic stretch signs are markedly positive on the right and left, in both the seated and supine position at 50-60. The medical record states that the patient has decreased sensation in a global distribution of the L1-S1 dermatomes and global weakness of unknown magnitude in the L3-S1 myotomes. The deep tendon reflexes are 2+ and normal, however. There is no record that temperature, vibration, or position sense has been examined. Absent from exam is any mention of atrophy, hypertrophy or symmetry of the lower extremity musculature. Also absent is mention of hypotonia, spasticity or rigidity in the extremities. There is no evaluation of meningeal signs. There is no documentation as to whether the patient is experiencing bowel or bladder problems and no documentation of saddle anesthesia.

IMR ISSUES, DECISIONS AND RATIONALES

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

URGENT NCV right lower extremity: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back, NCS.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Nerve conduction studies (NCS).

Decision rationale: According to the Official Disability Guidelines, nerve conduction studies are not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Neurological testing procedures have limited overall diagnostic accuracy in detecting disc herniation with suspected radiculopathy.

EMG left lower extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310. Decision based on Non-MTUS Citation ODG Low Back, EMGs.

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 - Lumbar & Thoracic (Acute & Chronic), EMGs (electromyography).

Decision rationale: The recorded physical examination of 10/23/2013 is discordant with the patient history and MRI findings. In fact, it seems to indicate paraparesis with no definite single radicular component. From the report, all sensory levels L1-S1 and all myotomes L3-S1 are

involved bilaterally. The ACOEM Guidelines state that electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. According to the Official Disability Guidelines, EMG's are recommended as an option and may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious.

NCV left lower extremity: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back, NCS.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Nerve conduction studies (NCS).

Decision rationale: According to the Official Disability Guidelines, nerve conduction studies are not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Neurological testing procedures have limited overall diagnostic accuracy in detecting disc herniation with suspected radiculopathy.

EMG right lower extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310. Decision based on Non-MTUS Citation ODG Low Back, EMGs.

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 - Lumbar & Thoracic (Acute & Chronic), EMGs (electromyography).

Decision rationale: The recorded physical examination is lacking documentation for signs of radiculopathy, either subtle or clinically obvious. The ACOEM Guidelines state that electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. According to the Official Disability Guidelines, EMG's are recommended as an option and may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious.