

<b>Case Number:</b>	CM15-0015649		
<b>Date Assigned:</b>	02/03/2015	<b>Date of Injury:</b>	05/12/2001
<b>Decision Date:</b>	03/26/2015	<b>UR Denial Date:</b>	12/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/27/2015

### 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: New Jersey, Michigan, California  
 Certification(s)/Specialty: Neurology, Neuromuscular 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 55 year old female, who sustained an industrial injury on May 12, 2001. The diagnoses have included radiculitis of right L4, facet arthropathy, and foraminal stenosis. Treatment to date has included a rhizotomy on March 10, 2014, physical therapy, and medications. Currently, the injured worker complains of constant low back and right leg pain. The Treating Physician's report dated December 3, 2014, noted the injured worker with pain in the right back, lateral hip, anterior thigh, and some down the in the lateral calf, with previous hip surgery that was noted not to make the pain go away. The Physician noted a slight leg length discrepancy, and pain with resisted straight leg raising on that side but no real bad pain with hip range of motion. On December 15, 2014, Utilization Review non-certified a MRI of the lumbar spine and an electromyography (EMG)/nerve conduction velocity (NCV) of the right lower extremities, noting that with normal physical examination findings, and lack of documentation of previous diagnostic imaging, the requests could not be deemed medically necessary. The MTUS Chronic Pain Medical Treatment Guidelines, and MTUS American College of Occupational and Environmental Medicine (ACOEM) Guidelines, Low Back Complaints, were cited. On January 27, 2015, the injured worker submitted an application for IMR for review of a MRI of the lumbar spine and an electromyography (EMG)/nerve conduction velocity (NCV) of the right lower extremities.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Magnetic Resonance Imaging (MRI) Lumbar Spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines.

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

**Decision rationale:** Regarding the indications for imaging in case of back pain, MTUS guidelines stated: Lumbar spine x rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. However, it may be appropriate when the physician believes it would aid in patient management. Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminate imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures). Furthermore, and according to MTUS guidelines, MRI is the test of choice for patients with prior back surgery, fracture or tumors that may require surgery. The patient does not have any clear evidence of new lumbar nerve root compromise. There is no clear evidence of significant change in the patient signs or symptoms suggestive of new pathology. Therefore, the request for lumbar MRI is not medically necessary.

**Electromyography/Nerve Conduction Velocity (EMG/NCV) Right Lower Extremity: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines.

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

**Decision rationale:** According to MTUS guidelines (MTUS page 303 from ACOEM guidelines), 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. EMG has excellent ability to identify abnormalities related to disc protrusion (MTUS page 304 from ACOEM guidelines). According to MTUS guidelines, needle EMG study helps identify subtle neurological focal dysfunction in patients with neck and arm symptoms. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study Electromyography (EMG), and nerve

conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks (page 178). EMG is indicated to clarify nerve dysfunction in case of suspected disc herniation (page 182). EMG is useful to identify physiological insult and anatomical defect in case of neck pain (page 179). Although the patient developed low back pain, there is no clear evidence that the patient developed peripheral nerve dysfunction or nerve root dysfunction. MTUS guidelines does not recommend EMG/NCV without signs of radiculopathy or nerve dysfunction. Therefore, the request for EMG/NCV study of the right lower extremities is not medically necessary.