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| **Case Number:** | CM15-0111802 | | |
| **Date Assigned:** | 06/18/2015 | **Date of Injury:** | 06/12/2008 |
| **Decision Date:** | 07/22/2015 | **UR Denial Date:** | 05/05/2015 |
| **Priority:** | Standard | **Application Received:** | 06/09/2015 |

## 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
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 69-year-old male, who sustained an industrial injury on 6/12/08. He has reported initial complaints of a back injury after a slip and fall accident at work. The diagnoses have included pseudoarthrosis, failed fusion at L5-S1 level and bilateral foraminal stenosis from bone spur formation. Treatment to date has included medications, activity modifications, diagnostics, physical therapy, chiropractic, surgery, other modalities and home exercise program (HEP). Currently, as per the physician progress note dated 4/28/15, the injured worker complains of continued severe mechanical axial back pain and left greater than right leg radiculopathies including pain, numbness and weakness. The physical exam reveals tenderness to palpation in the lumbar area with muscle spasm and painful range of motion. There is decreased trunk range of motion and diminished strength throughout. The sensation is diminished in the right S1 dermatomal distribution. The diagnostic testing that was performed included computerized axial tomography (CT scan) scan of the lumbar spine dated 4/17/15 reveals status post extensive fusion and laminectomy. There is disc protrusion with bilateral foraminal narrowing, facet joint hypertrophy, and residual osteophytic ridge resulting in bilateral foraminal narrowing. The physician noted that he needs to further gain diagnosis of his symptomology. The physician requested treatments included Magnetic Resonance Imaging (MRI) lumbar spine to see the exact nature of the discs above the level of the fusion, Aqua therapy due to muscle de- conditioning causing issues to the low back that needs core strengthening and electromyography (EMG) /nerve conduction velocity studies (NCV) bilateral lower extremities to rule out possible peripheral nerve involvement and to see if there is an ongoing compression of nerves versus degeneration or nerves versus a lack of overall ability to improve.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI lumbar:** 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) - Low Back Chapter, Indications for imaging-Magnetic resonance imaging.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178. Decision based on Non-MTUS Citation Official disability guidelines Low back chapter, MRIs (magnetic resonance imaging).

**Decision rationale:** Based on the 04/28/15 progress report provided by treating physician, the patient presents with low back and left sacroiliac joint pain that radiates down the left leg to knee, rated 8/10. The patient is status post revision L5-S1 fusion 01/17/14, and inguinal hernia repair 11/19/14. The request is for MRI LUMBAR. Patient's diagnosis per Request for Authorization form dated 04/28/15 includes severe mechanical axial back pain from discogenic and facet mediated origin, and failed fusion at L5-S1. The patient ambulates with antalgic gait. Physical examination to the lumbar spine on 04/28/15 revealed spasm and tenderness to palpation to paravertebral muscles. Range of motion was painful and reduced, especially on extension 10 degrees. Decreased sensation at S1 dermatomal distribution. Treatment to date has included surgery, diagnostics, physical therapy, chiropractic, home exercise program, activity modifications, and medications. Patient's medications include Norco, Prilosec, Percocet and Soma. The patient is to remain off-work, per 02/05/15 report. Treatment reports were provided from 01/23/14 - 05/05/15. ACOEM Guidelines, chapter 8, page 177 and 178, state "Unequivocal objective findings that identify specific nerve compromise on the neurological examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. " ODG Guidelines do not support MRIs unless there are neurologic signs/symptoms present. Repeat MRI's are indicated only if there has been progression of neurologic deficit. ODG guidelines, Low back chapter, MRIs (magnetic resonance imaging) (L-spine) state that "for uncomplicated back pain MRIs are recommended for radiculopathy following at least one month of conservative treatment. " ODG guidelines further state the following regarding MRI's, "Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation). "Treater noted that he needs to further gain diagnosis of the patient's symptomology. The physician requested treatments included Magnetic Resonance Imaging (MRI) lumbar spine to see the exact nature of the discs above the level of the fusion, According to guidelines, for an updated or repeat MRI, the patient must be post-operative or present with a new injury, red flags such as infection, tumor, fracture or neurologic progression. In this case, a postoperative lumbar MRI would appear to be indicated by guidelines. However, the patient had MRI of the lumbar spine on 03/25/11, per medical bill dated 11/04/14 provided in medical records. This patient does not present with any other condition to warrant another repeat MRI study. Therefore, the request IS NOT medically necessary.

**Aqua therapy:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy, Physical medicine Page(s): 22, 98-99.

**Decision rationale:** Based on the 04/28/15 progress report provided by treating physician, the patient presents with low back and left sacroiliac joint pain that radiates down the left leg to knee, rated 8/10. The patient is status post revision L5-S1 fusion 01/17/14, and inguinal hernia repair 11/19/14. The request is for AQUA THERAPY. Patient's diagnosis per Request for Authorization form dated 04/28/15 includes severe mechanical axial back pain from discogenic and facet mediated origin, and failed fusion at L5-S1. The patient ambulates with antalgic gait. Physical examination to the lumbar spine on 04/28/15 revealed spasm and tenderness to palpation to paravertebral muscles. Range of motion was painful and reduced, especially on extension 10 degrees. Decreased sensation at S1 dermatomal distribution. Treatment to date has included surgery, diagnostics, physical therapy, chiropractic, home exercise program, activity modifications, and medications. Patient's medications include Norco, Prilosec, Percocet and Soma. The patient is to remain off-work, per 02/05/15 report. Treatment reports were provided from 01/23/14 - 05/05/15. MTUS Guidelines page 22, Chronic Pain Medical Treatment Guidelines: Aquatic therapy is recommended as an optional form of exercise therapy where available, as an alternative to land-based physical therapy. Aquatic therapy (including swimming) can minimize effect of gravity, so it is specifically recommended where reduced weight-bearing is desirable, for example extreme obesity. For recommendations on the number of supervised visits, see physical medicine. Water exercise improved some components of health related quality of life, balance, and stair climbing in females with fibromyalgia, but regular exercise and higher intensities may be required to preserve most of these gains. MTUS page 98 and 99 has the following: "Physical medicine: recommended as indicated below. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self- directed home physical medicine." MTUS Guidelines page 98 and 99 states that for myalgia and myositis, 9 to 10 visits are recommended over 8 weeks and for myalgia, neuritis, and radiculitis, 8 to 10 visits are recommended. The patient is no longer within postoperative treatment period. Treater noted that he needs to further gain diagnosis of the patient's symptomology. The physician requested treatments included Aqua therapy due to muscle de-conditioning causing issues to the low back that needs core strengthening. Per 01/13/15 report, treater recommends "a repeat course of post lumbar spine surgery physical therapy. Patient limited in participation due to hernia. Hernia now repaired." In this case, there are no discussions as to why the patient cannot participate in traditional weight-bearing exercises and how aquatic therapy will benefit him. There is no mention that the patient is extremely obese and there is no rationale for patient's need for weight reduced exercises, or details about the need for the use of specialized equipment. It appears aqua therapy was an adjunct modality included in patient's physical therapy. In this case, physical therapy notes dated 01/17/14 to 01/29/15 indicate the patient has attended 35 visits. Additional physical therapy would exceed MTUS recommendation. Furthermore, the request for an unspecified amount of aqua therapy sessions cannot be warranted, and would not be in accordance with guidelines. Therefore, the request IS NOT medically necessary.

**EMG/NCV bilateral lower extremities:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand 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 Low Back Chapter, Nerve conduction studies Low Back Chapter, Electrodiagnostic studies (EDS).

**Decision rationale:** Based on the 04/28/15 progress report provided by treating physician, the patient presents with low back and left sacroiliac joint pain that radiates down the left leg to knee, rated 8/10. The patient is status post revision L5-S1 fusion 01/17/14, and inguinal hernia repair 11/19/14. The request is for EMG/NCV BILATERAL LOWER EXTREMITIES. Patient's diagnosis per Request for Authorization form dated 04/28/15 includes severe mechanical axial back pain from discogenic and facet mediated origin, and failed fusion at L5-S1. The patient ambulates with antalgic gait. Physical examination to the lumbar spine on 04/28/15 revealed spasm and tenderness to palpation to paravertebral muscles. Range of motion was painful and reduced, especially on extension 10 degrees. Decreased sensation at S1 dermatomal distribution. Treatment to date has included surgery, diagnostics, physical therapy, chiropractic, home exercise program, activity modifications, and medications. Patient's medications include Norco, Prilosec, Percocet and Soma. The patient is to remain off-work, per 02/05/15 report. Treatment reports were provided from 01/23/14 - 05/05/15. ACOEM Guidelines page 303 allows for EMG studies with H-reflex test to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than 3-4 weeks. Regarding Nerve conduction studies, ODG guidelines Low Back Chapter, under Nerve conduction studies states, "Not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. " ODG for Electrodiagnostic studies (EDS) states, "(NCS) which are not recommended for low back conditions, and EMGs (Electromyography) which are recommended as an option for low back. "Treater noted that he needs to further gain diagnosis of the patient's symptomology. The physician requested treatments included electromyography (EMG) /nerve conduction velocity studies (NCV) bilateral lower extremities to rule out possible peripheral nerve involvement and to see if there is an ongoing compression of nerves versus degeneration or nerves versus a lack of overall ability to improve. UR letter dated 05/05/15 states "there's been no documented change in the claimant's alleged conditions. Results of prior EMG testing were not provided. " However, review of medical records do not indicate patient had prior EMG of the lower extremities. Given the patient's continued complaints of pain and leg components and postoperative status, further diagnostic testing may be useful to obtain unequivocal evidence of radiculopathy. Medical records do not indicate electrodiagnostic studies of the lower extremities has been done following L5-S1 fusion surgery on 01/17/14. The request for EMG of the bilateral lower extremities appears reasonable and in accordance with guidelines. Therefore, the request IS medically necessary.