

Case Number:	CM15-0119543		
Date Assigned:	06/30/2015	Date of Injury:	05/04/2013
Decision Date:	07/29/2015	UR Denial Date:	06/17/2015
Priority:	Standard	Application Received:	06/22/2015

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: North Carolina
 Certification(s)/Specialty: Family Practice

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 57 year old male, who sustained an industrial injury on 5/04/2013, while employed as a bus driver. He reported a motor vehicle accident. The injured worker was diagnosed as having lumbar stenosis. Treatment to date has included diagnostics, physical therapy, L5-S1 discectomy on 11/12/2014, and medications. Several progress reports refer to lumbar spinal surgery in 10/2014. Currently (6/08/2015), the injured worker complains of continued back and right leg pain, rated 10/10. He was worse with any activity or movement and believed that he needed a fusion at L5-S1. He walked with a limp, did not use a cane, and no foot drop was noted. Bowel and bladder function were okay. He was mostly sedentary and sitting/standing were for a matter of minutes. He was able to toe and heel walk, but limped on his right leg. He had good strength and subjective numbness in the right leg. Knee and ankle jerks were present and toes were downgoing. He was unable to do range of motion testing. His medications included Oxycodone, Hydrocodone, Tizanidine, and Oxycontin. He was documented as vociferous with embellished pain behaviors. It was documented that only pre-operative films were available for review. The documented impression was post-laminectomy syndrome with poor outcome after recent discectomy. The treatment plan included magnetic resonance imaging of the lumbar spine (with and without contrast), x-ray of the lumbar spine (flexion and extension views), and electromyogram and nerve conduction studies of the bilateral lower extremities. Electromyogram and nerve conduction studies of the left lower extremity from 11/2013 were referenced, along with magnetic resonance imaging of the lumbar spine from 8/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the lumbar spine with and without contrast, per 06/08/15 order, QTY: 1: 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): 303-304.

Decision rationale: The ACOEM chapter on low back complaints and special diagnostic studies states: 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. Indiscriminant 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, computed tomography [CT] for bony structures). Relying solely on imaging studies to evaluate the source of low back and related symptoms carries a significant risk of diagnostic confusion (false positive test results) because of the possibility of identifying a finding that was present before symptoms began and therefore has no temporal association with the symptoms. Techniques vary in their abilities to define abnormalities (Table 12-7). Imaging studies should be reserved for cases in which surgery is considered or red-flag diagnoses are being evaluated. Because the overall false-positive rate is 30% for imaging studies in patients over age 30 who do not have symptoms, the risk of diagnostic confusion is great. There is no recorded presence of emerging red flags on the physical exam. There is evidence of nerve compromise on physical exam but there is not mention of consideration for surgery or complete failure of conservative therapy. For these reasons, criteria for imaging as defined above per the ACOEM have not been met. Therefore, the request is not medically necessary.

X-ray of the lumbar spine, flexion and extension views, per 06/08/15 order, QTY: 1:
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): 303-304.

Decision rationale: The ACOEM chapter on low back complaints and special diagnostic studies states: 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. Indiscriminant 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, computed tomography [CT] for bony structures). Relying solely on imaging studies to evaluate the source of low back and related symptoms carries a significant risk of diagnostic confusion (false positive test results) because of the possibility of identifying a finding that was present before symptoms began and therefore has no temporal association with the symptoms. Techniques vary in their abilities to define abnormalities (Table 12-7). Imaging studies should be reserved for cases in which surgery is considered or red-flag diagnoses are being evaluated. Because the overall false-positive rate is 30% for imaging studies in patients over age 30 who do not have symptoms, the risk of diagnostic confusion is great. There is no recorded presence of emerging red flags on the physical exam. There is evidence of nerve compromise on physical exam but there is not mention of consideration for surgery or complete failure of conservative therapy. For these reasons, criteria for imaging as defined above per the ACOEM have not been met. Therefore, the request is not medically necessary.

EMG/NCS of the bilateral lower extremities, per 06/08/15 order, QTY: 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Nerve Conduction Studies (NCS).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

Decision rationale: The ACOEM chapters on low back complaints and the need for lower extremity EMG/NCV states: 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. Indiscriminant 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). 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. There are unequivocal objective findings of nerve compromise on the neurologic exam provided for review. However, there is not mention of surgical consideration. There are no unclear neurologic findings on exam. For these reasons, criteria for lower extremity EMG/NCV have not been met as set forth in the ACOEM. Therefore, the request is not medically necessary.