

<b>Case Number:</b>	CM15-0144161		
<b>Date Assigned:</b>	08/05/2015	<b>Date of Injury:</b>	08/01/2005
<b>Decision Date:</b>	10/08/2015	<b>UR Denial Date:</b>	06/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/24/2015

### 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 York, Tennessee

Certification(s)/Specialty: Emergency 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 with an industrial injury date of 12-2004 to 08-2006 cumulative trauma. (Injury date in utilization review is 08/01/2005). His diagnoses included status post lumbar fusion, status post HNP with interbody disc prosthesis and radiculopathy - lower extremities. Prior treatment included epidural steroid injection, physical therapy, psychological evaluation, lumbar surgery, aqua therapy and medications. He presented on 06-10-2015 with complaints of low back pain. Objective findings included tenderness, spasm and guarding of lumbar 4-5 and lumbar 5-sacral 1. The treatment plan included continue home exercise program, Prilosec, EMG and nerve conduction studies of lower extremity, CT scan of lumbar spine, referral to neurologist and return in 4 weeks. The request for neurology consultation and follow up office visit was authorized. The treatment requests for review are: Range of Motion Testing, Prilosec 20 MG Qty 90, NCS RLE, NCS LLE, Lumbar Spine CT Scan, EMG RLE, EMG LLE.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Prilosec 20 MG Qty 90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

**Decision rationale:** Prilosec is omeprazole, a proton pump inhibitor (PPI). PPI's are used in the treatment of peptic ulcer disease and may be prescribed in patients who are using non-steroidal anti-inflammatory drugs and are at high risk for gastrointestinal events. Risk factors for high-risk events are age greater than 65, history of peptic ulcer, GI bleeding or perforation, concurrent use of ASA, corticosteroids, and/or an anticoagulant, or high dose/multiple NSAID (e.g., NSAID + low-dose ASA). In this case, the patient had superficial ulcerations on EGD secondary to NSAID use. The NSAIDs were discontinued. The request is not medically necessary. The request should not be authorized.

**Range of Motion Testing:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**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, Flexibility.

**Decision rationale:** Range of motion testing is a measure of flexibility. Flexibility is not recommended as primary criteria, but should be a part of a routine musculoskeletal evaluation. The relation between lumbar range of motion measures and functional ability is weak or nonexistent. The value of the sit-and-reach test as an indicator of previous back discomfort is questionable. The request is not medically necessary.

**Lumbar Spine CT Scan:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Online.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Lumbar & Thoracic: CT (computed tomography).

**Decision rationale:** Imaging of the lumbosacral spine is indicated in patients with unequivocal objective findings that identify specific nerve compromise on the neurologic examination 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. Further investigation is indicated in patients with history of tumor, infection, abdominal

aneurysm, or other related serious conditions, who have positive findings on examination. Indications for computed tomography are as follows: Thoracic spine trauma: equivocal or positive plain films, no neurological deficit, Thoracic spine trauma: with neurological deficit- Lumbar spine trauma: trauma, neurological deficit, Lumbar spine trauma: seat belt (chance) fracture, Myelopathy (neurological deficit related to the spinal cord), traumatic- Myelopathy, infectious disease patient, Evaluate pars defect not identified on plain x-rays, Evaluate successful fusion if plain x-rays do not confirm fusion. In this case the patient had CT of the lumbar spine on January 2011 and February 18, 2013. There is no documentation in the medical record that there has been a significant change in the patient's condition or that there any red flags. Medical necessity has not been established. The request is not medically necessary.

**EMG RLE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies, Summary.

**Decision rationale:** EMGs (electromyography) are recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. 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. In this case the patient had EMG/NCS studies of the lower extremities in May 2012 and November 2013. There is no documentation in the medical record that there has been a significant change in the patient's condition or that there ant neurologic deficits. Medical necessity has not been established. The request is not medically necessary.

**EMG LLE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies, Summary.

**Decision rationale:** EMGs (electromyography) are recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. 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. In this case the patient had EMG/NCS studies of the lower extremities in May 2012 and November 2013. There is no documentation in the medical record that there has been a significant change in the patient's

condition or that there are neurologic deficits. Medical necessity has not been established. The request is not medically necessary.

**NCS RLE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**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-Thoracic and Lumbar, Nerve Conduction Studies.

**Decision rationale:** 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. This systematic review and meta-analysis demonstrate that neurological testing procedures have limited overall diagnostic accuracy in detecting disc herniation with suspected radiculopathy. In the management of spine trauma with radicular symptoms, EMG/nerve conduction studies (NCS) often have low combined sensitivity and specificity in confirming root injury, and there is limited evidence to support the use of often uncomfortable and costly EMG/NCS. In this case the patient had EMG/NCS studies of the lower extremities in May 2012 and November 2013. There is no documentation in the medical record that there has been a significant change in the patient's condition or that there are neurologic deficits. Medical necessity has not been established. The request is not medically necessary.

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