

Case Number:	CM15-0149597		
Date Assigned:	09/03/2015	Date of Injury:	07/31/2014
Decision Date:	10/21/2015	UR Denial Date:	07/25/2015
Priority:	Standard	Application Received:	08/01/2015

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, Pain Management

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 49 year old male, who sustained an industrial injury on July 31, 2014. The injured worker reported continuous trauma injury to the lumbar spine, left knee, left hip, sciatica, and sleep issues secondary to daily repetitive work activities. The injured worker was diagnosed as having lumbar spine sprain and strain with rule out herniated nucleus pulposus, status post arthroscopy of the left knee, left knee sprain and strain rule out internal derangement, and mild insomnia secondary to pain. Treatment and diagnostic studies to date has included a medication regimen. In a progress note dated June 26, 2015 the treating physician reports complaints of pain to the left and midline sides of the low back that radiates to the left buttock and thigh along with associated symptoms of numbness and sleep disturbance; complaints of intermittent, sharp, aching pain to the left lateral hip radiating to the buttock and the left lower back with associated symptoms of numbness to the calf; complaints of constant left knee pain; complaints of intermittent, moderate, pressure, aching pain to the sciatica that radiates to the left calf and low back with associated symptoms of numbness; and occasional sleep disturbance. Examination reveals tenderness to the bilateral paralumbar muscles with the left greater than the right, tenderness to the right gluteus maximus muscle, tenderness to the spinous process at lumbar four, lumbar five, and sacral one, decreased range of motion to the lumbar spine with pain that radiates to the low back, left lower extremity, positive heel walk test, tenderness to the left knee joint, tenderness to the semitendinosus and semimembranosus tendons, pain with range of motion to the left knee, possible positive McMurray's testing, left leg spasm to the gastrocnemius muscle, and decreased sensation to the left lower extremity to the lumbar four to five dermatome. The treating physician requested magnetic resonance imaging of the lumbar

spine to evaluate the neuroforaminal, intervertebral discs, and the spinal nerve roots to assess for findings of the left lower extremity radiculopathy noted on physical examination along with a request for magnetic resonance imaging of the left knee to rule out internal derangement. The treating physician requested an electromyogram and nerve conduction study of the left lower extremity to confirm the physical findings of the specific level of radiculitis and specific nerve root involvement. The treating physician requested an initial functional capacity evaluation to assess for baseline level of work capabilities. The treating physician also requested a patient injury prevention class to instruct on proper body mechanics, joint conservation, and joint prevention techniques to prevent re-injury or increasing of symptoms.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 MRI of the lumbar spine: Overturned

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

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 Chapter, MRI Topic.

Decision rationale: Regarding the request for lumbar MRI, ACOEM Practice Guidelines state that 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 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. ODG states that MRIs are recommended for uncomplicated low back pain with radiculopathy after at least one month of conservative therapy. Within the documentation available for review, a progress note on 6/26/2015 indicated that the patient has decreased motor strength of left lower extremity compare to the right, and reduced sensation in the L4-L5 dermatome. These findings suggest specific nerve compromise. Given this, the currently requested lumbar MRI is appropriate and medically necessary.

1 EMG/NCS of the left lower extremity: Overturned

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back, Lumbar & Thoracic (Acute & Chronic) - Nerve conduction studies.

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 Chapter, Electrodiagnostic Studies.

Decision rationale: Regarding the request for EMG and nerve conduction study of the left lower extremity, ACOEM Chapter 12 states that unequivocal objective findings that identify specific nerve compromise on the neurologic exam are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery. When a neurologic examination is less clear however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. They go on to state that electromyography may be useful to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting

more than 3 to 4 weeks. Within the documentation available for review, a progress note on 6/26/2015 indicated that the patient has decreased motor strength of left lower extremity compare to the right, and reduced sensation in the L4-L5 dermatome. These findings suggest specific nerve compromise. Given this, the currently requested EMG and nerve conduction study of the left lower extremity is appropriate and medically necessary.

1 initial functional capacity evaluation: 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), Fitness for duty: Functional capacity evaluations (FCE).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty Chapter, Functional Capacity Evaluation and Other Medical Treatment Guidelines ACOEM, Chapter 7, p. 137-138.

Decision rationale: Regarding request for functional capacity evaluation, ACOEM Practice Guidelines state that there is not good evidence that functional capacity evaluations are correlated with a lower frequency of health complaints or injuries. ODG states that functional capacity evaluations are recommended prior to admission to a work hardening program. The criteria for the use of a functional capacity evaluation includes case management being hampered by complex issues such as prior unsuccessful return to work attempts, conflicting medical reporting on precautions and/or fitness for modified job, or injuries that require detailed explanation of a worker's abilities. Additionally, guidelines recommend that the patient be close to or at maximum medical improvement with all key medical reports secured and additional / secondary conditions clarified. Within the documentation available for review, there is no indication that there has been prior unsuccessful return to work attempts, conflicting medical reporting, or injuries that would require detailed exploration. Given this, the currently requested functional capacity evaluation is not medically necessary.

1 patient injury prevention class: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg (Acute & Chronic) - Education.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://www.spdc.msu.edu/uploads/files/Programs/CM/Events/Safety_Training_Program/Presentations/English_Version/Module-5-MSU_SH-26316-SH_March_26_2015.pdf.

Decision rationale: Regarding the request for patient injury prevention class, there is not specific guidelines from ACOEM or CA MTUS; therefore, an alternative source is quoted. Due to a limited amount of resources, a study on warehouse steel workers conducted by the Michigan State University under the grant of Occupational Safety and Health Administration is cited. It states that injury prevention classes help demonstrate understanding of the principles of ergonomics and their applications: use good work practices, including proper lifting techniques, demonstrate awareness of work tasks that may lead to pain or injury, and recognize early symptoms of muscular skeletal disorders. Within the submitted documentation, there is

documentation work related injury with repetitive motion stress. However, the patient is deemed disabled and is currently not working. The provider did not state why such education cannot take place in a one on one in office setting. Furthermore, there are no guidelines to support of the use of this type of educational classes. As such, there is no clear indication for the patient injury prevention class and it is not medically necessary.

1 MRI of the left knee: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Knee Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter, MRI Topic.

Decision rationale: Regarding the request for MRI of the left knee, ACOEM Practice Guidelines state that reliance only on imaging studies to evaluate the source of knee symptoms may carry a significant risk of diagnostic confusion (false-positive test results) because of the possibility of identifying a problem that was present before symptoms began, and therefore has no temporal association with the current symptoms. The ODG Indications for MRI of the knee include the following: Acute trauma to the knee, including significant trauma (i.e., motor vehicle accident), or if suspect posterior knee dislocation or ligament or cartilage disruption; Non-traumatic knee pain, child or adolescent: non-patellofemoral symptoms. Initial anteroposterior and lateral radiographs non-diagnostic (demonstrate normal findings or a joint effusion) next study if clinically indicated. If additional study is needed; Non-traumatic knee pain, child or adult. Patellofemoral (anterior) symptoms. Initial anteroposterior, lateral, and axial radiographs non-diagnostic (demonstrate normal findings or a joint effusion). If additional imaging is necessary, and if internal derangement is suspected; Non-traumatic knee pain, adult. Non-trauma, non-tumor, non-localized pain. Initial anteroposterior and lateral radiographs non-diagnostic (demonstrate normal findings or a joint effusion). If additional studies are indicated, and if internal derangement is suspected; Non-traumatic knee pain, adult non-trauma, non-tumor, non-localized pain. Initial anteroposterior and lateral radiographs demonstrate evidence of internal derangement (e.g., Peligrini Stieda disease, joint compartment widening). Within the medical information made available for review, a progress note on 6/26/2015 indicated that the patient had a questionable McMurray's test of the left knee. However, there is no documentation that radiographs are non-diagnostic, identification of any red flags or documentation that conservative treatment aimed towards the left knee has failed. In the absence of such documentation, the currently requested MRI of the left knee is not medically necessary.