MAXIMUS Federal Services

Case Number:	CM15-0179046		
Date Assigned:	09/21/2015	Date of Injury:	04/13/2015
Decision Date:	10/23/2015	UR Denial Date:	08/31/2015
Priority:	Standard	Application Received:	09/11/2015

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 36-year-old male, who sustained an industrial injury on 04-13-2015. He has reported subsequent low back pain radiating to the lower extremities and neck pain radiating to the upper extremities and was diagnosed with cervical and lumbar strain, bilateral cervical radiculopathy and bilateral knee patellofemoral degenerative joint disease. X-rays of the bilateral knees on 08-17-2015 showed lateral patellofemoral narrowing to 1.7 mm bilaterally, x-rays of the lumbar spine on 08-17-2015 showed mild disc height loss at L5-S1 and x-rays of the cervical spine on 08-17-2015 showed well-maintained disc heights with no instability or fracture. Treatment to date has included oral pain medication and 12 sessions of physical therapy, which were noted to have failed to significantly relieve the pain. The only medical documentation submitted is a primary treating physician's orthopedic spine surgery consultation note dated 08-17-2015. On this date, the injured worker reported neck pain rated as 3 out of 10 with medication and 6 out of 10 without medication and low back pain radiating to the bilateral anterior thighs rated as 2-3 out of 10 with medication and 4-7 out of 10 without medication. Objective examination findings showed tenderness over the base of the cervical spine, with palpable spasms over the right trapezius over the medial scapular border, decreased sensation over the bilateral C6 and right C7 dermatomes, decreased range of motion of the cervical spine, tenderness to palpation over the L5-S1 paraspinal musculature and coccyx and decreased range of motion of the lumbar spine. The physician noted that due to neck pain and upper extremity pain that was not improving a request for MRI of the cervical spine would be made to determine if there was any stenosis and electromyography-nerve conduction studies (EMG-NCS) would be requested due to decreased sensation in the C6 and right C7 dermatome. The physician also noted that a request for MRI of the lumbar spine would be made due to no symptom

improvement in 4 months and due to subjective radiculopathy EMG-NCV of the lower extremities was being requested. Work status was documented as temporarily totally disabled. A request for authorization of 1 MRI of the cervical spine without contrast, 1 electromyography-nerve conduction study of the bilateral upper and lower extremities and 1 MRI of the lumbar spine without contrast was submitted. The requests for authorization of 1 MRI of the cervical spine without contrast, 1 electromyography-nerve conduction study of the bilateral upper and lower extremities and 1 MRI of the lumbar spine without contrast were non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 MRI of the cervical spine without contrast: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies.

Decision rationale: The ACOEM chapter on neck and upper back complaints and special diagnostic studies states: Criteria for ordering imaging studies are: Emergence of a red flag. Physiologic evidence of tissue insult or neurologic dysfunction. Failure to progress in a strengthening program intended to avoid surgery. Clarification of the anatomy prior to an invasive procedure. The provided progress notes fails to show any documentation of indications for imaging studies of the neck as outlined above per the ACOEM. There was no emergence of red flag. The neck pain was characterized as unchanged. The physical exam noted no evidence of new tissue insult or neurologic dysfunction. There is no planned invasive procedure. Therefore, criteria have not been met for a MRI of the neck and the request is not medically necessary.

1 EMG/NCV bilateral upper and lower extremities: Upheld

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

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

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.

1 MRI of the lumbar spine without contrast: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation ACOEM Practice Guidelines Chapter 12 (Low Back Complaints: Special Studies and Diagnostic and Treatment Considerations) (2007) page 53.

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

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 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.