

Case Number:	CM15-0179779		
Date Assigned:	09/21/2015	Date of Injury:	10/01/2008
Decision Date:	10/27/2015	UR Denial Date:	09/04/2015
Priority:	Standard	Application Received:	09/14/2015

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 31 year old male, who sustained an industrial injury on 10-1-08. Medical record indicated the injured worker is undergoing treatment for status post lumbar microdiscectomy-laminectomy, lumbar spine degenerative disc disease with facet arthropathy, transitional anatomy and lumbar radiculopathy. Treatment to date has included lumbar microdiscectomy-laminectomy, oral medications including Flexeril 7.5mg, ibuprofen, Tylenol and Aleve; topical Ketoprofen cream, home exercise program, 12 physical therapy visits, 12 visits physical therapy post microdiscectomy-laminectomy, 16 sessions of acupuncture, 5 sessions of chiropractic therapy and activity modifications. Currently on 8-4-15, the injured worker complains of continued low back pain with increased numbness in both lower extremities since last visit of 4-6-15; he says the numbness can be so severe he needs to hold onto a wall in order to walk and rates his back pain for 3-6 out of 10; he currently rates his pain 4 out of 10. Physical exam performed on 8-4-15 revealed mildly antalgic gait, decreased lumbar range of motion and limited by pain, decreased sensation at L4, 5 and S1 dermatomes on left. The treatment plan included (MRI) magnetic resonance imaging of lumbar spine and (EMG) Electromyogram-(NCS) Nerve Condition Velocity studies of lower extremities (previous studies in 2012) and a prescription for Gabapentin 600mg #60. On 9-4-15, utilization review non-certified a request for repeat (NCS) Nerve Condition Velocity of bilateral lower extremities noting there is minimal justification for performing (NCS) Nerve Condition Velocity studies when a patient is presumed to have symptoms on the basis of radiculopathy, in this case there is

a recommendation for repeat (MRI) magnetic resonance imaging of lumbar spine which appears is more reasonable and might be adequate to determine further treatment plan.

IMR ISSUES, DECISIONS AND RATIONALES

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

Repeat NCS of bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter.

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.