

<b>Case Number:</b>	CM13-0020104		
<b>Date Assigned:</b>	04/25/2014	<b>Date of Injury:</b>	02/03/2011
<b>Decision Date:</b>	06/10/2014	<b>UR Denial Date:</b>	08/16/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/04/2013

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 underlying date of injury in this case is 02/03/2011. This patient's diagnosis is recurrent left lumbar decompression due to L5-S1 disc protrusion. On 07/12/2013, the claimant was seen in orthopedic evaluation. The orthopedic surgeon reviewed this patient's history of original injury when she injured her low back lifting a champagne box. The patient was noted to have a history of microscopic laminectomy/discectomy at L5-S1 and neuroplasty L5 and S1 roots. The subsequent repeat MRI scan of 03/07/2013 demonstrated broad-based recurrent or residual central disc protrusion at L5-S1 with local enhancement and also enhancement at the S1 root. On exam the patient had hypoesthesia in an L5 and S1 distribution. The treating physician recommended electrodiagnostic studies in order to objectify the patient's radiculopathy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**EMG LEFT LOWER EXTREMITY:** 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.

**Decision rationale:** The ACOEM Guidelines, chapter 12/low back, page 303, recommends MRI imaging when a patient has unequivocal findings to suggest nerve compromise. This guideline recommends electrodiagnostic studies instead to demonstrate more subtle neural dysfunction or to identify additional findings not diagnosable by MRI imaging. In this case, the medical records by medical history, by surgical history, by examination, and by MRI imaging all document the presence of an L5-S1 disc protrusion and related radiculopathy. The medical records do not discuss an additional differential diagnosis, such as a peripheral neuropathy, to be assessed by electrodiagnostic studies. Not only are electrodiagnostic studies redundant given the other items in the history, but additionally electrodiagnostic studies would not likely be helpful and could give false positive findings. Given this patient's surgical history, it is probable that nerve conductions and particularly new exam findings may indefinitely demonstrate residual effects of the patient's prior spinal injury even after the patient clinically improves. The guidelines do not suggest that the requested electrodiagnostic studies would be effective at the stated goal of objectifying the patient's radiculopathy. This request is not medically necessary.

**EMG RIGHT LOWER EXTREMITY:** 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.

**Decision rationale:** The ACOEM Guidelines, chapter 12/low back, page 303, recommends MRI imaging when a patient has unequivocal findings to suggest nerve compromise. This guideline recommends electrodiagnostic studies instead to demonstrate more subtle neural dysfunction or to identify additional findings not diagnosable by MRI imaging. In this case, the medical records by medical history, by surgical history, by examination, and by MRI imaging all document the presence of an L5-S1 disc protrusion and related radiculopathy. The medical records do not discuss an additional differential diagnosis, such as a peripheral neuropathy, to be assessed by electrodiagnostic studies. Not only are electrodiagnostic studies redundant given the other items in the history, but additionally electrodiagnostic studies would not likely be helpful and could give false positive findings. Given this patient's surgical history, it is probable that nerve conductions and particularly new exam findings may indefinitely demonstrate residual effects of the patient's prior spinal injury even after the patient clinically improves. The guidelines do not suggest that the requested electrodiagnostic studies would be effective at the stated goal of objectifying the patient's radiculopathy. This request is not medically necessary.

**NCV LEFT LOWER EXTREMITY:** 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.

**Decision rationale:** The ACOEM Guidelines, chapter 12/low back, page 303, recommends MRI imaging when a patient has unequivocal findings to suggest nerve compromise. This guideline recommends electrodiagnostic studies instead to demonstrate more subtle neural dysfunction or to identify additional findings not diagnosable by MRI imaging. In this case, the medical records by medical history, by surgical history, by examination, and by MRI imaging all document the presence of an L5-S1 disc protrusion and related radiculopathy. The medical records do not discuss an additional differential diagnosis, such as a peripheral neuropathy, to be assessed by electrodiagnostic studies. Not only are electrodiagnostic studies redundant given the other items in the history, but additionally electrodiagnostic studies would not likely be helpful and could give false positive findings. Given this patient's surgical history, it is probable that nerve conductions and particularly new exam findings may indefinitely demonstrate residual effects of the patient's prior spinal injury even after the patient clinically improves. The guidelines do not suggest that the requested electrodiagnostic studies would be effective at the stated goal of objectifying the patient's radiculopathy. This request is not medically necessary.

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