

Case Number:	CM13-0028622		
Date Assigned:	03/28/2014	Date of Injury:	10/14/2003
Decision Date:	04/30/2014	UR Denial Date:	10/01/2013
Priority:	Standard	Application Received:	10/17/2013

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 Occupational Medicine, 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 patient is a 49 year old male who was injured on 10/14/2003. The patient felt something snap in his back and he was told that it was his iliosacral ligament. He subsequently developed cauda equina. Prior treatment history has included chiropractic adjustments, Flexeril, and Valium. The patient underwent anterior and posterior fusion at L4 to S1 on 08/21/2006. He had a hernia repair of the abdomen in May 2007, also in 2008 and 2010 up to 13 times altogether. He a placement of spinal cord stimulator paddle lead, advanced bionic expanding T8 to T9 with laminectomy T9-T10. Diagnostic studies reviewed include: MRI of the lumbar spine performed on 06/11/2012 revealed: 1) Prior L4 through S1 fusion without complications 2) No evidence of nerve root impingement 3) Chronic L5-S1 spondylolisthesis 4) There is an 8 mm slip anterolisthesis of L5 on S1. 5) There is minimal retrolisthesis of L1-2 on L2-3 6) L1-L2 shows partial desiccation of the disc 7) L2-L3, no disc protrusion; No central canal stenosis 8) L3-L4, no disc protrusion; No central canal stenosis 9) L4-L5, artifact related intervertebral cage grafts, bilateral pedicle screws 10) Central canal is widely patent 11) L5-S1, intervertebral cage graft ad bilateral pedicle screws; central canal is widely patent. CAT scan of the lumbar spine performed on 10/01/2007 revealed L5 out of alignment and some compromise of the cord and L4 which shows a large black area in the center presumably from his fracture. Ultrasound of the abdomen performed on 07/29/2008 revealed an essentially normal finding except for the 2 cages and 3 sets of screws in the back, total of 6 screws. Agreed Qualified Medical Examination report dated 12/05/2013 indicated in 2005, he developed what he thinks in retrospect was cauda equine syndrome. The patient states his back bothers him now with sitting crouching, standing, stooping, walking, kneeling, climbing, lifting, bending pushing and pulling but not balancing .The pain at the moment is moderate and most of the time he has inability to travel. The pain limits him some of the time with social activities, most of the time. He states that it is worse in

the morning, afternoon, and night. The patient has a spinal cord stimulator which helps with a great deal of the pain being reduced since it was implanted. The pain is dull ache, sometimes sharp, sometimes burning, sometimes pinching, and sometimes tingling. . When asked directly what the sexual problem is he says, "My lower stomach and pelvic area is numb." His lower limbs are sometimes numb. Objective findings on neurological exam revealed a left lower extremity foot drop; reflexes in the right knee are 3+ and in the left knee 2+. The right ankle 1+, left ankle 1+; toes are down going; straight leg raising is positive at 90 degrees, right and left supine was well as sitting. Sensation reveals dullness to pain and pin on the left lower extremity, inner thigh, and lateral thigh. The left medial calf is none. The left lateral calf is normal, 50/50. There is no pain or pin sensation in the left heel, left ball of the foot, left toe or medial foot. This goes all the way up to the abdomen where there is numbness below the mid upper, more so on the left than the right. The patient can walk on his heels, but Final Determination Letter for IMR Case Number [REDACTED] the right toe walking is very weak on the left. There is weakness of the extensor hallucis longus, 1/5 on the left. His Romberg is negative; straight leg rising is normal. There is no drift; rapid sequence motions are done well. The back has an 8 inch verticals scar. . The patient's diagnoses include: 1) Mild to moderate cauda equine syndrome with mainly anal impediments featured. There is numbness in the genital area and the lower legs interfering with genital sensation. 2) Status post back injury with fusion to 1997 status post back injury 3) Delayed ejaculation syndrome 4) Urinary frequency 5) Urinary urgency

IMR ISSUES, DECISIONS AND RATIONALES

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

ELECTROMYOGRAPHY (EMG) OF THE BILATERAL LOWER EXTREMITIES:

Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303, 304, 309.

Decision rationale: According to the CA MTUS guidelines, EMG is recommended to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks, and not recommended for clinically obvious radiculopathy. The medical records document that this patient has obvious signs and symptoms of cauda equina syndrome consisting of foot drop on the left side, urinary urgency, and sexual dysfunction. There are objective findings of diminished reflexes, decreased anal tone, and patch areas of numbness in L5 through S3 dermatomes. These findings correlate with subjective complaints. Thus, the records documented clearly indicate clinically obvious radiculopathy is present; and thus, the request for EMG of bilateral lower extremity is not medically necessary according to the guidelines.

NERVE CONDUCTION STUDIES (NCS) FOR THE BILATERAL LOWER EXTREMITIES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG), LOW BACK, NERVE CONDUCTION STUDIES (NCS).

Decision rationale: CA MTUS guidelines do not specifically address the issue in dispute and hence ODG have been consulted. According to the ODG, "NCS is not recommended; there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy." In this case, this patient clearly has evidence of radiculopathy and hence the medical necessity has not been established and the request is non-certified