

Case Number:	CM13-0042062		
Date Assigned:	12/27/2013	Date of Injury:	11/05/2012
Decision Date:	02/28/2014	UR Denial Date:	10/04/2013
Priority:	Standard	Application Received:	10/16/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Pain Management, has a subspecialty in Disability Evaluation 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 physician 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 58-year-old male who sustained an injury on 11/05/2012 when he was driving a forklift and another forklift crashed into his. The patient experienced immediate pain in his neck and lower back. He has been treated with acupuncture, chiropractic sessions, and physical therapy but has experienced minimal improvement. The patient returned to work with modified duties however he reported symptom worsening in his neck and back as a result. The patient is currently temporarily totally disabled. An MRI of the lumbar spine was done on 06/28/2013 that revealed at L3-4 7mm lateral herniated disc migrating and impinging the left existing nerve root, L4-5 minimal lateral disc bulges with facet arthropathy causing mild neural foramen narrowing, and L5- S1 4-5 mm disc bulge extending into the right neural foramen with a 5-6 mm left lateral disc protrusion/extrusion extending into the left neural foramen. The patient is currently prescribed Tramadol. On 06/12/13, needle electromyography of bilateral upper extremities was performed which showed chronic bilateral C7 radiculopathies and chronic denervation in left flexor carpi ulnaris, rule out ulnar neuropathy at the elbow. On 06/28/13, an MRI of the lumbar spine was obtained which showed the following: 1) L3-L4, 7mm left lateral herniated (extruded) disc migrating superiorly in left neural foramen impinging upon and deviating the left exiting nerve roots 2) L4-L5 minimal lateral bulges greater on the left with facet arthropathy causing mild narrowing of the neural foramen 3) L5-S1, 4-5 mm broad-based disc bulge extending into right neural foramen, with a 5-6 mm left lateral disc protrusion/extrusion extending into left neural foramen; facet arthropathy contributed to moderate right and severe left foraminal stenosis with bilateral impingement upon exiting nerve roots, left greater than right. On 03/22/13- electromyography and nerve conduction studies of left lower extremity were performed which revealed the following: 1). Normal needle electromyography with no electrodiagnostic evidence of active or chronic motor radiculopathy. A normal needle electromyography did not exclude the

possibility of motor radiculopathy. 2). There was no electrodiagnostic evidence of generalized peripheral neuropathy. Testing one extremity only did not rule out the possibility of a peripheral neuropathy. In a primary treating physician return visit on 09/13/13, the patient continued to have intermittent lower back pain with radiation of pain to the left buttocks and posterior thigh. His low back pain was located in the midline of L4, L5, and S1 which was aggravated by prolonged sitting and waist bending. He also complained of thoracic spine pain. He had lower mid back pain and stiffness located in the midline of T8, T9, and T12. His symptoms were unchanged. He had also cervical spine pain. Cervical spine examination showed 3+ diffuse tenderness to palpation in the lower third posterior cervical muscles and mid trapezius area, left worse than right; limited range of motion with slight and mild pain at end range and negative Spurling's sign bilaterally. Lumbar spine examination revealed mild lumbar straightening; 3+ tenderness to palpation; hyper tonicity in paraspinal musculature; focal tenderness to the left L4-L5; and limited range of motion was moderate lower back pain. Thoracic Spine examination showed moderate hypertonicity and tenderness in the mid thoracic paravertebral and interscapular muscles. The patient was diagnosed with sprains and strains of other and unspecified parts of back, neck; anterior longitudinal (ligament), cervical: sprains and strains of other and unspecified parts of back, thoracic spine; sprains and strains of sacroiliac region, lumbosacral joint; and cervical intervertebral disc displacement without myelopathy; neuritis (brachial) or radiculitis due to displacement. He was requested to have electromyography/nerve conduction Studies of bilateral lower ext

IMR ISSUES, DECISIONS AND RATIONALES

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

Decision for (EMG) Electromyography and (NCS) Nerve Conduction Studies for the Right Lower Extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation ODG-TWC-Low Back - Lumbar & Thoracic (Acute & Chronic)

Decision rationale: With respect to Electromyography and Nerve Conduction, the guideline states EMG's are not necessary if radiculopathy is already clinically obvious as is the case with this patient. ACOEM(2004) page 303, 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. Diskography is not recommended for assessing patients with acute low back symptoms. Also ODG-TWC-Low Back - Lumbar & Thoracic (Acute & Chronic)(12/27/2013) EMGs (electromyography); Recommended as an option (needle, not surface). EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. (Bigos, 1999) (Ortiz-Corredor, 2003) (Haig, 2005) No correlation was found between intraoperative EMG findings and immediate postoperative pain, but intraoperative spinal cord monitoring is becoming more common and there may be benefit in

surgery with major corrective anatomic intervention like fracture or scoliosis or fusion where there is significant stenosis. (Dimopoulos, 2004) EMG's may be required by the AMA Guides for an impairment rating of radiculopathy. (AMA, 2001) (Note: Needle EMG and H-reflex tests are recommended, but Surface EMG and F-wave tests are not very specific and therefore are not recommended. Therefore, Decision for (EMG) Electromyography and (NCS) Nerve Conduction Studies for the Right Lower Extremity is not medically necessary and appropriate.