MAXIMUS Federal Services

Case Number:	CM13-0048022		
Date Assigned:	12/27/2013	Date of Injury:	05/26/2012
Decision Date:	02/20/2014	UR Denial Date:	09/05/2013
Priority:	Standard	Application Received:	10/09/2013

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain 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 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 injured worker is a 43-year-old female with a date of injury of May 26, 2012. She has been diagnosed with lumbar spine musculoligamentous sprain and strain. A lumbar MRI performed on August 1, 2012 review slight disc height loss with slight desiccation at L2-3 and L3 for with moderate facet hypertrophy bilaterally. There was also mild lateral recess narrowing contacting the traversing L5 rootlets at L4 - five with facet arthropathy, "with attendant bilateral lower extremity radiculitis." This is documented in a Primary Treating Physician's Supplemental Report dated January 13, 2014. A utilization review of the request for authorization for bilateral lower extremity electro diagnostic study requested on June 19, 2013 was non-certified. The stated rationale for the denial was that "no detailed, legible assessment plan report/exam was provided. There is alleged low back pain and BLE pain/radicular symptoms."

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303,Chronic Pain Treatment Guidelines Page(s): 6.

Decision rationale: Section Â§ 9792.23.5 Low Back Complaints of the California Code of Regulations, Title 8, page 6 states the following: "The Administrative Director adopts and incorporates by reference the Low Back Complaints (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12) into the MTUS from the ACOEM Practice Guidelines." In Chapter 12 of the ACOEM Guidelines, page 303, the following reference regarding electro diagnostic testing is noted: "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." ACOEM Practice Guidelines 2nd Ed., Update to Chapter 12, Low Back Disorders, pgs. 60-61 states: "The nerve conduction studies are usually normal in radiculopathy (except for motor nerve amplitude loss in muscles innervated by the involved nerve root in more severe radiculopathy and H-wave studies for unilateral S1 radiculopathy). Nerve conduction studies rule out other causes for lower limb symptoms (generalized peripheral neuropathy, peroneal compression neuropathy at the proximal fibular, etc.) that can mimic sciatica." In the case of this injured worker, the low back pain is chronic and clearly beyond the timeframe as specified by ACOEM guidelines for consideration of EMG. Examination of the lumbar spine reveals tenderness to palpation with slight to moderate hypertonicity and muscle guarding over the lower lumbar paravertebral musculature and lumbosacral junctions bilaterally. Straight leg raise testing elicits complaints of increased low back pain only absent radicular component. Kemps test elicits increased low back pain upon extension and rotation. Neurologic examination reveals symmetric 2+ patellar and Achilles reflexes. Sensation is intact to light touch in the lower extremities. Normal muscle bulk and tone are noted with no evidence of atrophy of spasticity. Gait demonstrates a short in stride length without appreciable them. She is able to heel walk and toe walk but this results in low back pain. These findings are documented in a progress note on date of service October 25, 2013. Furthermore, it is documented that the patient has subjective complaints of numbness and tingling in her bilateral lower extremities. Given that the neurologic examination does not demonstrate clinically obvious radiculopathy, the request for electromyography and nerve conduction studies is recommended for certification for the purpose of identifying possible radiculopathy. Although nerve conduction studies are typically normal in cases of lumbar radiculopathy, they should be included in any electro diagnostic study because this normal results were to support a radiculopathy diagnosis and exclude other findings such as peripheral neuropathy, plexopathy, or mononeuritis.