Case Number:	CM13-0052272		
Date Assigned:	12/27/2013	**Date of Injury:**	03/31/2013
Decision Date:	06/20/2014	**UR Denial Date:**	11/13/2013
Priority:	Standard	**Application Received:**	11/14/2013

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 claimant was injured on 03/31/13. She was seen in an ED and did not have any neurologic deficits. She was discharged home. On 06/07/13, she had ongoing pain and physical therapy was ordered. She reported on 05/21/13 that she was injured from repetitive sitting on a stool with no back support and she had upper, middle, and lower back pain. She saw [redacted]. She had pain that radiated to her legs and wanted to go out on disability for a month as she never had pain this severe in her life. She was in mild to moderate distress and no neurologic deficits. She was diagnosed with a strain. On 06/07/13, she had back pain over 7/10 in the low back and upper mid was on and off. She had less pain. Physical therapy was ordered. She saw [redacted] on 07/02/13 and denied numbness or tingling in her legs. There was minimal spasm of the low back and full strength. Sensation and reflexes were intact and straight leg raise tests were negative. There was a significant psychological overlay to her chronic low back symptoms. She had an orthopedic evaluation on 07/29/13 and was diagnosed with a low back sprain. She had a mildly antalgic gait with pain referred to the low back and tenderness. Sitting straight leg raise test was positive on the right side. She saw [redacted] on 09/11/13 and had been approved for PT, acupuncture and open MRI of the low back. She had burning with intermittent bilateral lower extremity radiculopathy symptoms. She had low back pain with heel and toe walk and tenderness, but negative straight leg raise tests and full quadriceps strength bilaterally. On 11/13/13, an MRI of the low back was certified, but EMG/NCV of the lower extremities was not certified. She saw [redacted] and she reported slipping and falling on her buttocks onto a tiled floor on the date of injury. Her pain radiated to her lower extremities. She had attended physical therapy that did not help (previous notes indicated PT did help). She had x-rays and had received two acupuncture puncture sessions that gave her no relief. She had tenderness of the thoracic spine and low back. Straight leg raise was negative. She had decreased sensation to

pinprick and light touch along the L4 dermatomal pattern. There was no weakness and her reflexes were symmetric. She was diagnosed with sprains of the neck and back. MRI of the low back and EMG/NCV of the bilateral lower extremities were recommended. She was given medications. On 01/07/14, she had deep and sharp pain with weakness and decreased range of motion. She had tenderness of the trapezius muscles and paraspinal, cervical, and thoracolumbar spine with muscle guarding. Range of motion was significantly restricted. EMG/nerve conduction study was again recommended due to the persistence of her complaints. On 01/16/14, there is a letter appealing the denial of the EMG/nerve conduction study. The note states that she was attempting to sit on a stool with wheels and it slipped from underneath her and caused her to fall on the floor. She had decreased range of motion of the cervical, thoracic, and lumbar spine in all planes and sensation was decreased along the bilateral lower extremities in the L4 dermatome.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG OF THE BILATERAL LOWER EXTREMITIES: 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.

Decision rationale: The history and documentation do not objectively support the request for EMG of the bilateral lower extremities at this time. The CA MTUS/ACOEM Guidelines, chapter 12 state regarding Special Studies, "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." The claimant has had an MRI approved but there is no report of this study. It is not clear whether it was ever done and if not, why not. She has ongoing complaints with findings on physical examination that include decreased sensation and reports of radiating pain with positive straight leg raise tests on some dates (negative at other times). It is not clear how this study is likely to change her course of treatment prior to assessing the results of the MRI. EMG may be used, as per the CA MTUS to assess patients for neurologic deficits and findings of radiculopathy to assist in the decision to do an imaging study such as an MRI. However, an MRI has already been approved. The medical necessity of this request has not been clearly demonstrated under these circumstances. The request is not medically necessary.

NCV OF THE BILATERAL LOWER EXTREMITIES: 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. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Nerve Conduction Studies.

Decision rationale: The history and documentation do not objectively support the request for NCV of the bilateral lower extremities at this time. The CA MTUS/ACOEM Guidelines, chapter 12 state regarding Special Studies, "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." The MTUS do not specifically address the use of NCV under these circumstances. The ODG state "NCV are not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy." There is no evidence that peripheral nerve dysfunction is being evaluated. The medical necessity of this request has not been clearly demonstrated under these circumstances. The request is not medically necessary.