

Case Number:	CM13-0063931		
Date Assigned:	01/03/2014	Date of Injury:	02/03/2012
Decision Date:	04/15/2014	UR Denial Date:	11/27/2013
Priority:	Standard	Application Received:	12/09/2013

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 & Rehabilitation, has a subspecialty in Sports Medicine and is licensed to practice in Texas. 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 54-year-old female who reported injury on February 03, 2012. The mechanism of injury was not provided. The patient's diagnosis included lumbar spondylosis multilevel, lumbar radiculitis and history of lumbar stenosis per MRI. The patient had an electromyogram (EMG) on March 19, 2012, which revealed confirmation of a right S1 radiculopathy. The patient was treated with acupuncture. The patient had back stiffness and pain with paresthasias going down the leg. An MRI of the lumbar spine was done which confirmed multilevel spondylosis and anterolisthesis consistent with physical examination and functional deficits. The patient complaints on October 29, 2013 indicated that the patient was having achy, radiating, dull, stabbing and severe pain that went into the right leg and foot and down to the left part of the left thigh. It was intermittent when the patient was not working but when working it was constant. The patient indicated that acupuncture had been 60% to 80% helpful and effective along with chiropractic treatments. Objectively, the sensory examination in the lower extremities revealed paresthasia to light touch on the dorsal aspect of the left foot and lateral aspect of the left foot. Deep tendon reflexes were symmetric and physiologic at 2/4. The myotomal examination revealed the patient had knee flexion of 4/5 on the left and 4+/5 on the right and ankle plantar flexion, inversion, eversion, and extensor hallucis longus were 4/5 on the left and 4+/5 on the right. The patient had a positive sacroiliac (SI) joint compression test bilaterally. Treatment plan was noted to include a Functional Restoration Program and repeat EMG/NCV (nerve conduction velocity) test as it was more than a year since the previous one. The physician indicated that it was requested to check and see if the patient had progression of neurologic findings.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV OF THE BILATERAL LOWER EXTREMITIES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation ODG Low Back Chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Nerve conduction studies (NCS)

Decision rationale: The ACOEM states that 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. Clinical documentation submitted for review failed to indicate specific nerve compromise. There was a lack of documentation indicating the patient had changes in their physical examination and objective findings to support the need for repeat electromyography. Official Disability Guidelines does not recommend NCS, as there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms because of radiculopathy. Clinical documentation submitted for review indicated that the patient had radiculopathy per the previous EMG. There was a lack of documentation indicating a necessity for a repeat of both an EMG and an NCS. Given the above, the request for EMG/NCV of the bilateral lower extremities is not medically necessary.