

Case Number:	CM13-0068012		
Date Assigned:	02/14/2014	Date of Injury:	05/15/2012
Decision Date:	06/13/2014	UR Denial Date:	11/20/2013
Priority:	Standard	Application Received:	12/18/2013

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 Internal 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 43 year old female who was injured on 05/15/2012 while she was walking at the rear of a shirt printing machine and sustained a right ankle sprain resulting in a mechanical fall and subsequent back pain. She carries a diagnosis of lumbar spondylolisthesis L5-S1 with radiculopathy, lumbar strain and low back pain syndrome. Prior treatment history has included pain medications, extracorporeal shock wave procedure, and chiropractic therapy. Diagnostic studies reviewed include; MRI of the lumbar spine dated 07/10/2012 shows L5-S1 level can be postsurgical in origin in the appropriate context. There is Grade I anterolisthesis of L5 over S1. There is bilaterally neural foraminal compromise with effacement of the L5 nerve roots, left greater than right. Clinical correlation for pain and paresthesia in the distribution of L5 exiting nerve roots is advised. MRI of the lumbar spine with and without load bearing dated 09/18/2012 shows a broad-based protrusion and facet hypertrophy at L4-5 producing bilaterally neuroforaminal narrowing; disc measurements pre-axial loading 1-2 mm; L5-S1 grade 2 lytic spondylolisthesis of L5; combine with a disc protrusion and facet hypertrophy, there is spinal canal narrowing and bilaterally neuroforaminal narrowing; posterior annular tear/fissure; and there is no other significant findings noted. MRI of the lumbar spine dated 12/11/2013 revealed a grade I spondylolisthesis at L5-S1 with a small diffuse disc bulge and moderate facet hypertrophy causing mild neural foraminal stenosis bilaterally. Lower extremity Electromyography dated 09/11/2012 reveals normal study of the right lower extremity. There is no electrodiagnostic evidence of a neuropathic or a myopathic process in the right lower extremity. Along with the nerve study, there is no electrodiagnostic evidence of a neuropathy or plexopathy in the bilateral lower extremities or of a radiculopathy in the right lower extremity. There is no electrodiagnostic evidence of a neuropathic or a myopathic process in the right lower extremity on this study. Along with the nerve study there is no evidence of neuropathy,

plexopathy or radiculopathy in the right lower extremity or of a neuropathy or a plexopathy in the bilateral lower extremities. Clinical correlation is recommended. Electrodiagnostic report dated 10/19/2012 demonstrates pathology with left (L4) saphenous nerve 1+ (mild); right (L5) peroneal nerve 1+ (mild); right (L1) upper lumbar nerve -1(hyper). Office note dated 06/05/2013 states the patient presents with complaints of low back pain radiating to the left lower extremity to the knee. The patient's gait is abnormal and heel-toe walk is abnormal. On inspection of the lumbar spine, there is no lordosis, scoliosis, kyphosis; and 2-point palpation reveals paraspinous tenderness and tension is noted. There is tenderness at L4-5 and L5-S1 bilaterally. The patient is diagnosed with lumbar radiculopathy with radiculitis to the right lower extremity. Office note dated 07/09/2013 states the patient reports constant moderate to severe pain in the low back that radiates down the thighs and legs to the feet accompanied with numbness and tingling. The pain increases with sitting, standing and walking for prolonged periods, bending and twisting. She rates the pain as 5/9. On exam, the patient is noted to be standing erect with normal posture. Lumbar lordosis is normal and there is no evidence of scoliosis or increased thoracic kyphosis. Her hips and pelvis are level. There is tenderness to palpation about the lumbar paravertebral muscles at L5-S1 level bilaterally. There is no paravertebral muscle guarding or muscle spasm. There are no trigger points to palpation of the thoracic or lumbar muscles. Her gait is normal heel to toe; walking on tiptoes and heels does not increase pain. On neurologic exam, deep tendon reflexes were 2+ bilaterally. Sensation to pinprick and light touch is normal bilaterally. Motor strength is normal and symmetrical in all major muscle groups of the lower extremities. Straight leg raise is negative to 60 degrees bilaterally in the sitting and standing positions; cross straight leg mixing is negative bilaterally; sitting and supine Lasegue's are negative bilaterally.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG LEFT LOWER EXTREMITY: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: According to the CA MTUS/ACOEM, Electromyography (EMG), may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. The medical records document the patient complaining of chronic back pain radiating to the lower extremities associated with numbness/tingling. Interestingly, in the PR-2 dated 7/19/2013, neurologic exam revealed her deep tendon reflexes were 2+ bilaterally, sensation to pinprick and light touch is normal bilaterally, and motor strength was normal and symmetrical in all major muscle groups of the lower extremities. Electrodiagnostic report dated 10/19/2012 demonstrates pathology with left (L4) saphenous nerve 1+ (mild); right (L5) peroneal nerve 1+ (mild); and right (L1) upper lumbar nerve. Patient has also had MRI of the lumbar spine on 7/10/12 demonstrating Grade I anterolisthesis of L5 over S1, bilaterally neural foraminal compromise with effacement of the L5 nerve roots, left greater than right. Clinical correlation for pain and paresthesia in the distribution of L5 exiting nerve roots was advised. Since the patient has symptoms of radiculopathy and this is confirmed

objectively with MRI and electrodiagnostic studies, the diagnosis of radiculopathy is clear and the medical necessity to repeat these studies is not justified. Thus, the request is for EMG of left lower extremity is not certified.

NCV RIGHT LOWER EXTREMITY: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The medical records document the patient complaining of chronic back pain radiating to the lower extremities associated with numbness/tingling. Interestingly, in the PR-2 dated 7/19/2013, neurologic exam revealed her deep tendon reflexes were 2+ bilaterally, sensation to pinprick and light touch is normal bilaterally, and motor strength was normal and symmetrical in all major muscle groups of the lower extremities. Electrodiagnostic report dated 10/19/2012 demonstrates pathology with left (L4) saphenous nerve 1+ (mild); right (L5) peroneal nerve 1+ (mild); and right (L1) upper lumbar nerve. Patient has also had MRI of the lumbar spine on 7/10/12 demonstrating Grade I anterolisthesis of L5 over S1, bilaterally neural foraminal compromise with effacement of the L5 nerve roots, left greater than right. Clinical correlation for pain and paresthesia in the distribution of L5 exiting nerve roots was advised. Since the patient has symptoms of radiculopathy and this is confirmed objectively with MRI and electrodiagnostic studies, the diagnosis of radiculopathy is clear and the medical necessity to repeat these studies is not justified. Thus, the request is for NCV of right lower extremity is not certified.

NCV LEFT LOWER EXTREMITY: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: According to the ODG, there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. The medical records document the patient complaining of chronic back pain radiating to the lower extremities associated with numbness/tingling. Interestingly, in the PR-2 dated 7/19/2013, neurologic exam revealed her deep tendon reflexes were 2+ bilaterally, sensation to pinprick and light touch is normal bilaterally, and motor strength was normal and symmetrical in all major muscle groups of the lower extremities. Electrodiagnostic report dated 10/19/2012 demonstrates pathology with left (L4) saphenous nerve 1+ (mild); right (L5) peroneal nerve 1+ (mild); and right (L1) upper lumbar nerve. Patient has also had MRI of the lumbar spine on 7/10/12

demonstrating Grade I anterolisthesis of L5 over S1, bilaterally neural foraminal compromise with effacement of the L5 nerve roots, left greater than right. Clinical correlation for pain and paresthesia in the distribution of L5 exiting nerve roots was advised. Since the patient has symptoms of radiculopathy and this is confirmed objectively with MRI and electrodiagnostic studies, the diagnosis of radiculopathy is clear and the medical necessity to repeat these studies is not justified. Thus, the request is for NCV of left lower extremity is not certified.

EMG RIGHT LOWER EXTREMITY: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: According to the CA MTUS/ACOEM, Electromyography (EMG), may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. The medical records document the patient complaining of chronic back pain radiating to the lower extremities associated with numbness/tingling. Interestingly, in the PR-2 dated 7/19/2013, neurologic exam revealed her deep tendon reflexes were 2+ bilaterally, sensation to pinprick and light touch is normal bilaterally, and motor strength was normal and symmetrical in all major muscle groups of the lower extremities. Electrodiagnostic report dated 10/19/2012 demonstrates pathology with left (L4) saphenous nerve 1+ (mild); right (L5) peroneal nerve 1+ (mild); and right (L1) upper lumbar nerve. Patient has also had MRI of the lumbar spine on 7/10/12 demonstrating Grade I anterolisthesis of L5 over S1, bilaterally neural foraminal compromise with effacement of the L5 nerve roots, left greater than right. Clinical correlation for pain and paresthesia in the distribution of L5 exiting nerve roots was advised. Since the patient has symptoms of radiculopathy and this is confirmed objectively with MRI and electrodiagnostic studies, the diagnosis of radiculopathy is clear and the medical necessity to repeat these studies is not justified. Thus, the request is for EMG of right lower extremity is not certified.