

Case Number:	CM14-0123717		
Date Assigned:	08/08/2014	Date of Injury:	05/24/2011
Decision Date:	10/02/2014	UR Denial Date:	07/29/2014
Priority:	Standard	Application Received:	08/05/2014

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 and Rehabilitation and is licensed to practice in Georgia. 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 47 year old male who was injured on 05/24/2011 while he was riding a mower and slid down a hill, with a resultant low back injury. Prior treatment history has included physical therapy and chiropractic care. A progress report (PR) dated 12/19/2013 noted daily low-back and mid-back pain. NSAID and Neurontin were of clear benefit. The pain was aggravated by prolonged standing and heavy lifting. The pain rated 8/10. Lumbar spine range of motion exam noted 50% of expected motion. 2+ tenderness reported to palpation in the L4-L5 and L5-S1 levels. Paravertebral spasm was able to be evoked on the left at these levels with palpation. Knee and ankle reflexes "hyporeflexic" bilaterally. Motor exam of lower extremities did not reveal focal deficit. Sensory exam revealed blunting to pin on left leg at L4-L5 and L5-S1 distributions. Listed diagnoses included lumbar radicular signs and symptoms. 01/20/2014 states the patient presented for flaring of his low and mid back pain. Objective findings on exam revealed lumbar spine range of motion was 25% of expected at the L4-5 and L5-S1 levels. He had paravertebral spasms on the left which were evoked at these levels via palpation. There was 2+ tenderness to palpation at the L4-5 and L5-S1 levels. Diagnoses listed were lumbar disc disease, thoracic disc disease; left hip pain. A recommendation was made for EMG of bilateral lower extremities. PR dated 02/13/2014 noted the prescribed Medrol dosepak prescribed on 01/20/2014 was of benefit in relieving severe flaring spinal pain. NSAIDs and Neurontin were reportedly of clear benefit. Lumbar spine range of motion recorded as flexion 30%; extension 25%; right rotation 75%; left rotation 75%. No motor deficits noted. Patient documented as able to stand on one leg. Trendelenberg's sign was negative. Knee and ankle reflexes were documented as "hyporeflexic" bilaterally. Upper and lower extremity motor exams did not reveal focal deficits. Sensory exam of the upper and lower extremities revealed blunting to pin on the left leg in L4-L5 and L5-S1 distributions. Listed diagnoses included lumbar radicular signs and

symptoms. PR dated 02/27/2014 noted flaring low-back and mid-back pain. Lumbar spine range of motion recorded as flexion 30%; extension 25%; right rotation 75%; left rotation 75%. No motor deficits noted. Patient documented as able to stand on one leg. Trendelenberg's sign was negative. Knee and ankle reflexes were documented as "hyporeflexic" bilaterally. Upper and lower extremity motor exams did not reveal focal deficits. Sensory exam of the upper and lower extremities revealed blunting to pin on the left leg in L4-L5 and L5-S1 distributions. Listed diagnoses included lumbar radicular signs and symptoms. PR date 03/27/2014 is either identical or very nearly so to the PR from 02/27/2014. PR dated 05/01/2014 documented low back pain involving the lateral calves. It is also noted the patient has not worked since 01/10/2014. Pain rated 8/10. Lumbar spine flexion noted as 50% of normal, rotation documented as of normal. No motor deficits were found in the legs. Patient noted to be able to stand on one leg. Patient's reflexes were documented as "hyporeflexic" bilaterally at the ankle and knee. Motor examination of the upper and lower extremities did not reveal focal deficit. Sensory examination of the lower limbs revealed blunting to pin on left leg in L4-L5 and L5-S1 distributions. Listed diagnoses included: Lumbar Disc Disease; Lumbar Radicular Signs and Symptoms. PR dated 05/27/2014 is nearly identical to the 05/01/2014 note. PR dated 06/30/2014 is nearly identical to PR from 05/01/2014. Listed diagnoses are unchanged. PR dated 07/24/2014 noted identical complaints to 05/01/2014. Objective findings appear to be verbatim identical to PR from 05/01/2014. Listed diagnoses are unchanged. A Utilization review (UR) dated 06/29/2014 noted and MRI of the lumbar spine from 07/08/2011 (report not included with provided documentation) demonstrated DDD at L5-S1, with moderate central disc protrusion measuring 5mm, without definite nerve root compression. At L4-L5, a far right posterolateral disc protrusion was noted with foraminal stenosis and possible encroachment of the exiting L4 nerve root. An EMG performed 08/01/2011 was cited in the above UR, and reportedly demonstrated no evidence of lumbar radiculopathy, or peripheral nerve entrapment. Prior utilization review dated 07/29/2014 stated the request for Electromyogram (EMG) Bilateral Lower Extremities was denied as there was no documented objective clinical evidence to support the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electromyogram (EMG) Bilateral Lower Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), EMG, Knee and Leg Other Medical Treatment Guideline or Medical Evidence: Downs, MB, Laporte C. Conflicting dermatome maps: educational and clinical implications. Journal of Orthopaedic and Sports Physical Therapy. 2011; 41:427-434. Available at: <http://www.jospt.org/doi/pdf/10.2519/jospt.2011.3506>. Accessed September 24, 2014.

Decision rationale: The Official Disability Guidelines (ODG) note that electromyography (EMG) may be useful to obtain unequivocal evidence of radiculopathy, after 4-8 weeks of conservative therapy, but EMGs are noted to be unnecessary if radiculopathy is clinically obvious. The provided clinical documentation provides evidence of possible radicular symptoms, with noted sensory deficits documented at L4-L5 and L5-S1 on the left. There is well documented variability in available dermatome map models, as noted in the clinical

commentary cited above. Therefore, despite a previous UR noting the documented levels suggest a non-dermatomal origin, that the documented regions involve adjacent dermatomes suggests a radicular explanation is not out of the question. At issue, however, is a lack of documentation provided indicating what the patient's complaints were at the time of the EMG performed in 2011. Without documentation supporting a change in clinical status from examinations prior to the re-flare which occurred on 01/10/2014, there is no clear indication for a repeat EMG at this time. Therefore, based on the ODG guidelines and criteria as well as the clinical documentation stated above, the request is not medically necessary.