

Case Number:	CM14-0125658		
Date Assigned:	08/11/2014	Date of Injury:	08/24/2010
Decision Date:	09/11/2014	UR Denial Date:	07/31/2014
Priority:	Standard	Application Received:	08/07/2014

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, has a subspecialty in Sports Medicine 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 46 year old female who was injured on 08/27/2010. The injury reportedly occurred while manipulating a door which was stuck. Prior treatment history has included 6 sessions of acupuncture therapy, and physical therapy. A non-certification notice dated 03/03/2011 denied an authorization request form an EMG/NCV of the bilateral lower extremities for pain radiating into the lower extremities, with documented diminishment of sensation in the left medial and lateral leg and calf along with weakness of plantar flexors and halux elevation. A certification after reconsideration notice dated 12/27/2012 approved an EMG/NCV of the bilateral lower extremities at that time for worsening right-sided symptoms. A progress report (PR) dated 02/14/2014 noted a negative straight leg raise test. Diagnoses at that visit included lumbar disc degeneration-progressive at L4-L5, stable at L5-S1. A recommendation was made for 2-level instrumented spinal fusion at L4-L5 and L5-S1 after review of MRI. A PR dated 02/21/2014 noted the patient had complaints of low back pain axially radiating in mid back and occasionally shooting down in left leg with tingling, numbness and paresthesia. Manual motor strength is 5/5 except left EHL and plantar flexors 4/5. A PR dated 03/21/2014 again noted constant low back pain axially radiating in mid back and occasionally shooting down left leg with tingling, numbness, and paresthesia. Pain was rated 6-7/10 on VAS. Manual motor testing was again 5/5 except EHL and plantar flexors are 4/5. Diagnoses at this visit included Lumbar disc protrusion at L4-L5 and L5-S1 displacing the L5 nerve root, "MRI confirmed." A PR dated 04/18/2014 again noted exam findings as noted at prior visits, with worsening pain rated 7-8/10 on VAS. Exam findings included diminished sensation to light touch in medial and lateral border of left leg, calf and foot. A PR dated 05/16/2014 notes a positive stretch test. Continued diminished strength and sensation as previously documented was noted. A PR dated 06/05/2014 noted positive straight leg raise tests. Deep tendon reflexes were 2/2 for biceps, triceps,

brachioradialis, knee, and ankle joint. RFA dated 07/25/2014 stated the patient complained of symptomatic neck and low back pain. On exam, the cervical lumbosacral spine revealed decreased range of motion and tenderness to palpation. Motor strength was 5/5 in bilateral upper extremities and lower extremities. Deep tendon reflexes were 2+ in knee and ankle joint. Straight leg raise was positive bilateral legs. She had multiple myofascial trigger points in the cervical and lumbosacral paraspinal musculature. Diagnoses were lumbosacral sprain/strain injury; lumbosacral radiculopathy; cervical sprain/strain injury and myofascial pain syndrome. Recommendations were made to continue Norco 10/325 mg, Zanaflex and Ambien. Prior utilization review dated 07/31/2014 stated the request for EMG Bilateral Lower Extremities and NCV Bilateral Lower Extremities was denied as medical necessity has not been established.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG Bilateral Lower Extermities: 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), Low Back Chapter, Electromyography (EMG).

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 medical records document clear exam findings which are clinically diagnostic for radiculopathy, as well as MRI findings which support this diagnosis. Further, the documents show the patient had a previous EMG performed in or around 2012, with the radicular signs and symptoms documented more recently already manifesting (weakness of plantar flexion, EHL weakness, and diminished sensation in the medial and lateral lower leg). No documented changes are noted which might suggest a new neurologic issue or lesion which could warrant repeating an EMG. Based on the ODG criteria as well as the clinical documentation stated above, the request is not medically necessary.

NCV 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), Low Back Chapter, Electromyography (EMG).

Decision rationale: Per the Official Disability Guidelines (ODG), Nerve conduction studies (NCS) are not recommended when a patient is presumed to have symptoms on the basis of

radiculopathy. One systematic review cited in the reference chapter notes that there was little evidence to demonstrate the diagnostic accuracy of neurologic testing procedures in detecting disc herniation with suspected radiculopathy. The medical records document clear exam findings which are clinically diagnostic for radiculopathy, as well as MRI findings which support this diagnosis. Further, the documents show the patient had a previous NCS performed in or around 2012, with the radicular signs and symptoms documented more recently already manifesting (weakness of plantar flexion, EHL weakness, and diminished sensation in the medial and lateral lower leg). No documented changes are noted which might suggest a new neurologic issue or lesion which could warrant repeating an NCS. Based on the ODG criteria as well as the clinical documentation stated above, the request is not medically necessary.