

Case Number:	CM14-0173978		
Date Assigned:	10/27/2014	Date of Injury:	10/08/2012
Decision Date:	12/04/2014	UR Denial Date:	10/08/2014
Priority:	Standard	Application Received:	10/22/2014

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 Orthopedic Surgery, 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:

This 59-year-old male sustained an industrial injury on 10/8/12. The mechanism of injury was not documented. The 6/17/14 lumbar spine MRI impression documented facet spurring at L4/5 resulting in narrowing of the left lateral recess and abutment of the descending left L5 nerve root. There was mild to moderate left and mild right foraminal stenosis with mild central canal stenosis. At L5/S1, there was moderate to severe right and mild left foraminal stenosis secondary to facet spurring. The patient underwent a left total knee replacement on 7/17/14 and was off work. The 8/20/14 treating physician report cited mid-back and lumbosacral region pain with slight functional improvement following physical therapy. Neurologic exam documented equal deep tendon reflexes, intact sensation, and 5/5 motor strength with slight left lower extremity give away weakness. Lumbar range of motion was decreased in all directions with pain, spasms and diffuse tenderness at L5 and S1. The 9/18/14 initial treating physician report cited low back pain intermittently radiating down the left lower extremity to the calf with associated numbness and tingling. Pain was 9/10 and exacerbated with prolonged sitting, standing, and twisting. Pain reduced to 3/10 with medications, ice and heat. Physical exam documented moderate loss of lumbar flexion, painful flexion and exercise, 4/5 left 1st toe extension, mild left L5 paraspinal spasms, L5 and S1 spinous process tenderness, and moderate lumbosacral tenderness. Deep tendon reflexes were symmetrical. The diagnosis included lumbar facet syndrome and lumbar radiculopathy. A request for left lower extremity EMG/NCV was submitted. The 10/8/14 utilization review denied the request for left lower extremity EMG/NCV as the patient had been documented with lumbar radiculopathy and guidelines do not support electrodiagnostic testing as medically necessary if radiculopathy is already clinically obvious.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG of the left lower extremity: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation official disability guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 62-63.

Decision rationale: The California MTUS ACOEM guidelines state that EMG may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than 3 to 4 weeks. EMG is not recommended for clinically obvious radiculopathy or for patients with acute, subacute or chronic back pain who do not have significant leg pain or numbness. Electrodiagnostic studies are recommended when imaging is equivocal and there are on-going pain complaints that raise questions about whether there may be a neurologic compromise. Guideline criteria have been met. This patient has imaging evidence of left L5 nerve root pathology and has been diagnosed with lumbar radiculopathy. However, there are multi-level pathological changes in the distal lumbar sacral spine. There is a compelling reason to support the medical necessity of additional electrodiagnostic testing when a diagnosis of radiculopathy has been established without definitive localization of same. Therefore, this request is medically necessary.

NCV of the left lower extremity: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation official disability guidelines (ODG)

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 - Lumbar & Thoracic, Nerve conduction studies (NCS)

Decision rationale: The California MTUS do not address the medical necessity of NCV (nerve conduction velocity) testing for low back complaints. The Official Disability Guidelines state that nerve conduction studies are not recommended in low back injuries. Guidelines state that there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Guideline criteria have been met. This patient has imaging evidence of left L5 nerve root pathology and has been diagnosed with lumbar radiculopathy. However, there are multi-level pathological changes in the distal lumbar sacral spine. There is a compelling reason to support the medical necessity of additional electrodiagnostic testing when a diagnosis of radiculopathy has been established without definitive localization of same. Therefore, this request is medically necessary.