

<b>Case Number:</b>	CM14-0021037		
<b>Date Assigned:</b>	02/21/2014	<b>Date of Injury:</b>	08/13/2009
<b>Decision Date:</b>	07/21/2014	<b>UR Denial Date:</b>	12/26/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/09/2014

### 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 Neurology, has a subspecialty in Neurocritical care 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 48-year-old male with an 8/13/09 date of injury after a lifting a 50 pound bucket of ink. Chiropractic evaluation on 1/13/14 described pain in the cervical spine, lumbar spine, and right knee. Clinically there was reduced range of motion, tenderness, and spasms. SLR was noted to be positive on the right. On 12/9/13, the patient complained of neck pain, back pain, bilateral leg pain, right knee pain, stress, and anxiety. Clinically, there was reduced range of motion of the cervical spine, tenderness in the upper trapezius with spasms; lumbar spine reduced range of motion; positive SLR; and tenderness. In the right knee there was normal range of motion, tenderness at the medial and lateral joint line, and positive McMurray's. Imaging from 2013 and 2011 of the cervical and lumbar spine was referenced. Electrodiagnostic studies were performed in 2011 and 2013. The most recent 6/27/13 electrodiagnostic testing revealed moderate bilateral L4, L5, and S1 sensory radiculopathy. 6/8/13 MRI of the lumbar spine revealed at L2-3 disc bulge, mild bilateral foraminal narrowing; at L3-4 disc bulge, bilateral facet arthrosis, and mild bilateral neural foraminal narrowing; grade 1 anterolisthesis of L4, disc bulge with bilateral facet arthrosis, and moderate bilateral neural foraminal narrowing at L45. At L5-S1 disc bulge, bilateral facet arthrosis and marked right, and mild left neural foraminal narrowing. Treatment to date has included L3-4 and L4-5 decompression and fusion (2012), activity modification, PT, and medication.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**(EMG) ELECTROMYOGRAPHY LOWER EXTREMITIES:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

**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 Chapter.

**Decision rationale:** A request for electrodiagnostic studies obtained an adverse determination due to lack of comprehensive neurological examination of the lower extremities. There was no clear description of radiculopathy clinically, corresponding with MRI findings. This issue remains unaddressed. There is no recent comprehensive neurological examination, no clear description of conservative treatment, or progression in symptomatology. CA MTUS states that electromyography (EMG), including H-reflex tests, are indicated to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three to four weeks. In addition, ODG states that EMGs may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious. The patient underwent electrodiagnostic testing on 6/27/13, which revealed moderate bilateral L4, L5, and S1 sensory radiculopathy. It is unclear why repeat testing is necessary, when there is no discussion of failure of conservative treatments and progression of clinical findings/functional limitations. The request is not medically necessary.

**(NCV) NERVE CONDUCTION VELOCITY LOWER EXTREMITIES:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

**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 Chapter.

**Decision rationale:** A request for NCS obtained an adverse determination due to lack of comprehensive neurological examination of the lower extremities. There was no clear description of radiculopathy clinically, corresponding with MRI findings. This issue remains unaddressed. There is no recent comprehensive neurological examination, no clear description of conservative treatment, or progression in symptomatology. CA MTUS states that electromyography is indicated to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three to four weeks. NCS are not recommended when a patient is presumed to have symptoms on the basis of radiculopathy. There is no discussion regarding suspected peripheral nerve entrapment, requiring nerve conduction studies. The request is not medically necessary.