

<b>Case Number:</b>	CM14-0033480		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	06/24/2010
<b>Decision Date:</b>	09/25/2014	<b>UR Denial Date:</b>	02/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/17/2014

### 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 Family 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:

This is a 48 year old male who reported an industrial injury on 6/24/2010, over four (4) years ago, attributed to the performance of his customary job tasks reported as a uncontrolled descent in a crane bucket which casued the patient to strike the sides of the bucket. The patient was previously noted to have been assessed as permanent and stationary. The patient is not working. The patient complained of neck pain and stiffness; persistent pain and stiffness to the back radiating to the BLEs. The patient was noted to continue to use a wheelchair requiring assistance. The objective findings on examination included paraspinal tenderness with spasm; limited cervical motion; decreased grip strength; sensation was decreased and the bilateral C6 and C7 distributions; paraspinal tenderness to the lumbar spine with diminished range of motion; positive bilateral SLR; diminished quadriceps and hamstring strength; diminished sensation L5 and S1. The EMG/NCS dated 1/1/2012 demonstrated mild acute C7 and left L5 radiculopathy. The diagnoses included closed head trauma with postconcussion; cervical sprain/strain; disk protrusion and C7 radiculopathy; bilateral shoulder sprain/strain with adhesive capsulitis; status post shoulder dislocation; healed fracture of the left clavicle and scapula; lumbar sprain/strain; multiple disc bulges and L5 radiculopathy; left ankle sprain/strain. The patient also complained of headaches and growing pain. The MRI of the lumbar spine dated 6/20/2011 demonstrated evidence of L3-L4 with disc protrusion with effacement of the thecal sac; L4-L5 with disc protrusion with the effacement of the thecal sac; spinal canal slightly compromise; moderate narrowing of left lateral recess with effacement of the left L5 transiting nerve root and bilateral neural foraminal stenosis that effaces the L4 exiting nerve roots; L5-S1 with disc protrusion with effacement of the thecal sac and bilateral neural foraminal stenosis that effaces the L5 exiting nerve roots. The MRI of the cervical spine dated 6/20/2011 demonstrated C4-C5 and C6-C7 with

this protrusion having annular tear with effacement of the thecal sac and neural foraminal stenosis.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**EMG:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

**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 EMG and NCS.

**Decision rationale:** A number of screening tests and imaging studies were ordered by the requesting physician upon the initial evaluation of the patient. It was noted that the patient had been previously established as permanent and stationary. There were no documented interval changes in the objective findings on examination for the neck and upper extremities or the low back and upper extremities to support the medical necessity of repeated Electrodiagnostic studies. The requesting physician failed to document any interval changes in the neurological status of the patient to support the medical necessity of repeated Electrodiagnostic studies. The patient has MRIs of the cervical spine and lumbar spine, which fail to document a nerve impingement radiculopathy. The request for Electrodiagnostic studies was not specific as to the bilateral upper extremities or the bilateral lower extremities. There is no objective evidence of any changes in the neurological status of the patient to warrant repeated Electrodiagnostic studies. The patient was documented to have a specific neurological examination other than reported subjective leg numbness and the previously documented decreased in sensation to C7 and L5. There was no objective finding on examination of a sensory loss over a dermatomal distribution. There is no evidence of a nerve impingement radiculopathy on the previously obtained MRI of the lumbar spine. The neurological examination was documented as normal. The patient continues to complain of back pain radiating to the bilateral lower extremities. There were no demonstrated neurological deficits along a dermatomal distribution to the BLEs that were reproducible on examination. The patient was not noted to have any changes in clinical status. The patient had some subjective complaints of radiculitis; however, there were no documented objective findings on examination to support medical necessity. There is no demonstrated medical necessity for a BLE EMG for the pain management of this patient. The request for the authorization of the EMG of the bilateral lower extremities was not supported with any objective clinical findings that would demonstrate a change in the neurological status of the patient or demonstrate new or progressive neurological deficits in the lower extremities. There is no documented nerve impingement radiculopathy on imaging studies; however, there was a prior mild C7 and L5 radiculopathy by Electrodiagnostic study. There are no documented neurological findings that would suggest a progressive nerve entrapment neuropathy in the clinical documentation to the BLEs. The motor and sensory examination was documented to be unchanged from the status documented from the permanent and stationary report. There is no demonstrated medical necessity of an EMG to the bilateral lower extremities. There was no

rationale supported with objective evidence to support the medical necessity of repeated electrodiagnostic studies. Therefore, the request is not medically necessary.

**NCV:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

**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) back chapter EMG; NCS.

**Decision rationale:** A number of screening tests and imaging studies were ordered by the requesting physician upon the initial evaluation of the patient. It was noted that the patient had been previously established as permanent and stationary. There were no documented interval changes in the objective findings on examination for the neck and upper extremities or the low back and upper extremities to support the medical necessity of repeated Electrodiagnostic studies. The requesting physician failed to document any interval changes in the neurological status of the patient to support the medical necessity of repeated Electrodiagnostic studies. The patient has MRIs of the cervical spine and lumbar spine, which fail to document a nerve impingement radiculopathy. The request for Electrodiagnostic studies was not specific as to the bilateral upper extremities or the bilateral lower extremities. There is no objective evidence of any changes in the neurological status of the patient to warrant Electrodiagnostic studies. The patient was documented to have a normal neurological examination other than reported subjective lateral leg numbness. There was no objective finding on examination of a sensory loss over a dermatomal distribution. There is no evidence of a nerve impingement radiculopathy on examination. The neurological examination was documented as normal. The patient continues to complain of back pain. There were no demonstrated neurological deficits along a dermatomal distribution to the BLEs that were reproducible on examination. The patient was not noted to have any changes in clinical status. The patient had some subjective complaints of radiculitis; however, there were no documented objective findings on examination to support medical necessity. There is no demonstrated medical necessity for a BLE NCS for the pain management of this patient. The request for the authorization of the NCS of the bilateral lower extremities was not supported with any objective clinical findings that would demonstrate a change in the neurological status of the patient or demonstrate neurological deficits in the lower extremities. There is no documented nerve impingement radiculopathy. There are no documented neurological findings that would suggest a nerve entrapment neuropathy in the clinical documentation to the BLEs. The motor and sensory examination was documented to be normal. There is no demonstrated medical necessity for the requested NCS of the bilateral lower extremities. The request for the repeated electrodiagnostic studies was not specific as to the bilateral upper extremities or the bilateral lower extremities. There was no rationale supported with objective evidence to support the medical necessity of repeated Electrodiagnostic studies. Therefore, the request is not medically necessary.

