

Case Number:	CM14-0039626		
Date Assigned:	06/27/2014	Date of Injury:	11/06/2012
Decision Date:	08/18/2014	UR Denial Date:	03/04/2014
Priority:	Standard	Application Received:	04/04/2014

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 Occupational 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 36-year-old male patient with an 11/6/12 date of injury. He injured himself due to a motor vehicle accident. A progress report dated on 3/1/14 indicated that the patient continued to have pain in his lower back with shooting pain to the left leg. The shooting pain distributed along the posterior side of gluteus, thigh, kneecap, and ankle. He reported paresthesias with pins and needles in the left leg. Physical exam revealed restricted range of motion in the cervical spine and lumbar spine. There was tenderness to palpation over the lumbar paravertebral muscles at the level of left L5, S1. On a 3/17/14 progress report, the patient was recommended to have an EMG/NCV to rule out any source of radiculopathy or focal compression neuropathy to explain his symptomatology. MRI dated on 1/23/13 demonstrated L4-5 small bilateral osteophyte complexes of 2mm without foraminal stenosis, L5-S1 a small central to left paracentral disc bulge did not contact the thecal sac, no lateral recess stenosis. There was no nerve root compromise was present at any level of lumbar spine. He was diagnosed with low back pain with left S1 and L4 nerve root involvement, and disc herniation on L4-5 and L5-S1 as indicated in MRI. Treatment to date: medication management, epidural steroid injection. There is documentation of a previous 3/25/14 adverse determination, which was modified to only EMG for considered neuropathy. NCV was not certified because there was limited evidence of peripheral neuropathy.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG / NCV of the bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back Procedure Summary.

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: 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 stat 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. Furthermore, NCS are not recommended when a patient is presumed to have symptoms on the basis of radiculopathy. The patient presented with the pain in his lower back and shooting pain in the right lower extremity. He was recommended to have an EMG/NCV diagnostic study to rule out any radiculopathy and explain his symptomatology. However, there was a MRI dated 1/23/14 that demonstrated L4-5 small bilateral osteophyte complexes of 2mm without foraminal stenosis, L5-S1 a small central to left paracentral disc bulge did not contact the thecal sac, no lateral recess stenosis. There was no nerve root compromise present at any level of lumbar spine. In addition, there was modification in the recent UR decision to have only EMG. Therefore, the request for EMG / NCV of the bilateral lower extremities, as submitted, was not medically necessary.