

Case Number:	CM14-0046077		
Date Assigned:	07/02/2014	Date of Injury:	06/05/2002
Decision Date:	08/01/2014	UR Denial Date:	04/01/2014
Priority:	Standard	Application Received:	04/13/2014

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:

The claimant injured his low back on 6/5/02. He was diagnosed with a lumbar sprain and EMG/NCV is under review. He is status post fusion surgery at L4-5 in June 2009. He got 75% improvement after the surgery. He saw [REDACTED] on 10/28/13 and reported a severe recurrence of his low back pain with shooting sensation down to his right leg. An MRI showed additional discopathy. Neurologic examination revealed asymmetric reflexes which were decreased on the right side. He had moderate tenderness including over the facet joints. There was decreased range of motion. Sensory examination was intact. Straight leg raise was positive moreso on the right side. His strength was mildly decreased with right knee flexion and extension and right ankle dorsiflexion and plantar flexion. He had an ESI at level L2-3 bilaterally on 10/29/13. On 11/14/13, the second epidural was recommended per [REDACTED]. He was status post one ESI with good relief of leg pain. On 1/16/14, a second epidural was recommended by [REDACTED]. The progress report dated 3/14/14 states he still had low back pain and lower extremity numbness and tingling. The pain increased with activity. He was in no acute distress and had a normal gait without assistive devices. Lower symmetry strength was 5/5. He had an MRI on 8/2/13 that showed multilevel degenerative disc and facet disease most pronounced at L2-3 with a disc bulge and facet arthropathy causing moderate to severe central stenosis and mild to moderate bilateral foraminal stenosis. At T12-L1 there was severe right foraminal stenosis with compression of the exiting T12 nerve root. There were postsurgical changes at L5-S1 with fibrosis partially surrounding the descending left S1 nerve root. Nerve root compression was not excluded. He is status post epidural steroid injection with improvement for three days. His findings were unchanged on 6/2/14. He had ongoing pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG of the lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310. Decision based on Non-MTUS Citation Official Disability Guidelines - Electromyography.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

Decision rationale: The MTUS states that unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures). Electromyography (EMG), including H reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. The claimant has findings on an MRI and has had treatment based on those findings (epidural steroid injection) with only three days of pain relief. A repeat ESI has already been recommended. There is no history of new symptoms or findings to support proceeding with this type of study. Since an MRI has already been done and treatment has been started presumably for a diagnosis of radiculopathy, it is not clear how the results of this study would be likely to change his course of treatment. No new symptoms or focal neurologic deficits have been documented. The medical necessity of this request has not been clearly demonstrated.

NCV lower extremities: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Low Back, Nerve Conduction Studies.

Decision rationale: The MTUS does not address NCV for low back injuries, but the Official Disability Guidelines state that nerve conduction studies are not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. The claimant has findings on an MRI and has had treatment based on those findings (epidural steroid injection) with only three days of pain relief. A repeat ESI has already been recommended. There is no history of new symptoms or findings to support proceeding with this type of study. Since an MRI has already been done and treatment has been started presumably for a diagnosis of radiculopathy, it is not clear how the results of this study would be likely to change his course of treatment. No new symptoms or focal

neurologic deficits have been documented. There is no evidence of another neurologic abnormality, such as a peripheral nerve dysfunction. The medical necessity of this request has not been clearly demonstrated.