

Case Number:	CM14-0071757		
Date Assigned:	07/16/2014	Date of Injury:	06/19/2010
Decision Date:	09/15/2014	UR Denial Date:	04/30/2014
Priority:	Standard	Application Received:	05/19/2014

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:

According to the available information, this is a 59-year-old gentleman with the date of injury of 6/19/10. Mechanism of injury to the back was related to using a pallet jack. He had an L4-5/L5-S1 fusion on 7/10/12, the fusion was slow and bone stimulator was required in addition to pain management and analgesics. A 3/6/14 report from the spine surgeon says that they are awaiting an MRI of the lumbar spine with gadolinium to address persistent low back pain and radicular symptoms left lower extremity. Examination did not mention any neurologic deficits in the lower extremities. Diagnoses were status post lumbar fusion L4 5 and L5-S1 Lumbar discogenic disease. Post-traumatic catheterization and continued urologic problems, neck pain/strain. Electromyogram (EMG) and nerve conduction velocity (NCV) of the bilateral lower extremities were also prescribed. There is a 1/23/14 report from the same provider that reported significant interim worsening with pain 9/10, decreased functional status. Examination stated motor was intact bilaterally. There is negative straight leg raise bilaterally, no mention of any sensory changes. Radiographs from 1/23/14 of the lumbar spine showed that the position of hardware and fusion looks solid. MRI of the lumbar spine and EMG/NCV of the bilateral lower extremities was requested. A 12/12/13 report however indicated that the patient felt that he was slowly getting there. The low back pain has stabilized. Exam was again negative for any neurologic deficits of the lower extremities. Orthopedic AME (agreed medical examiner) on 9/23/13 documents subjective complaints injured worker had pain in the low back radiating to the right side and pins and needles radiating down the left leg to the left ankle. Pain was 8/10. Exam noted absent reflexes of the knee and ankle. No motor or sensory deficits were noted. Patient was status post lumbar spine anterior posterior fusion L4 5 and was so be Permanent and stationary (P&S). It was not felt that he would get significantly better. Future medical care was orthopedic surgical reevaluation, short courses of conservative care for flare-ups. It was stated

that he may require additional surgery in the future and should have access to that as well as additional diagnostic testing. There is also a provision for a neurology consult for post void dribbling. They are from the requesting provider and do not indicate that there was a specific reason for the patient's subjective worsening of pain between December 2013 and the January 2013 follow-up. There is no mention of new progressive radicular pain, numbness, tingling or weakness in the lower extremities and there was no documentation of any focal neurologic deficits in the lower extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG Bilateral lower extremities: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 296, 309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Back, Electrodiagnostic testing.

Decision rationale: ACOEM states that the diagnostic testing for lumbar sacral nerve root compression with radiculopathy should include symptoms of leg pain, numbness, weakness in specific distribution. Unique signs would include objectively, reflex changes, motor weakness in specific distribution, sensory changes in specific distribution, positive straight leg raise and positive crossed straight leg rising. Testing is not indicated unless compression is severe or progressive. Red flags would include cauda equina syndrome or rapidly progressive neurologic deficit which would require immediate studies. After no improvement after 1 month of conservative treatment then needle EMG and H reflex tests to clarify nerve root dysfunction are supported. EMG for clinically obvious radiculopathy is not needed. In this case, there are no new progressive neurologic deficits documented in the lower extremities and there are no clear radicular symptoms which are new in specific dermatomal distribution. There is no concern of cauda equina syndrome. The only neurologic deficits documented by the AME are diminished reflexes and these are likely chronic since before surgery. Thus based upon the evidence and the guidelines, this request is not considered to be medically necessary.

NCV Bilateral lower extremities: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 296, 309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) : back, electrodiagnostic testing.

Decision rationale: ACOEM guidelines do not even mention the use of nerve conduction velocities and diagnostic workup of lower back radiculopathy. ODG states that there is minimal

justification for performing nerve connector studies when a patient is presumed to have symptoms on the basis of radiculopathy. Thus, based upon the evidence and the guidelines, this is not approved.