

Case Number:	CM14-0073867		
Date Assigned:	07/16/2014	Date of Injury:	09/15/2000
Decision Date:	10/23/2014	UR Denial Date:	05/02/2014
Priority:	Standard	Application Received:	05/21/2014

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 09/15/2000. EMG/nerve conduction studies of the lower extremities are under review. He reportedly was injured while rolling a large piece of castors under a unit when he lost control and the apparatus flipped over. He is status post low back spine surgery in 12/2001 and a second surgery in 2004 and the third surgery in August 2013. He also had bilateral knee arthroscopic surgeries in the remote past. He had diffuse degenerative changes on x-rays. On 03/11/2014, he was evaluated. Additional treatment was recommended. He had significant low back pain and diffuse pain in the right foot and ankle and sharp pain along the longitudinal arch on the left. With his different surgeries he had relief of his foot and ankle complaints and never had any foot and ankle injuries. These symptoms were thought to be coming from the lumbar spine. EMG/NCV studies of the lower extremities were recommended. MRI was also recommended to rule out ongoing neural encroachment. He had a significantly affected gait. He needed to see a spine specialist. He also had obvious foot drop and a left-sided AFO was recommended. He had low back pain that was always aching and occasionally sharp, stabbing, and burning that varied in intensity but was constant. It radiated to the right buttocks and entire left lower extremity. He complained of drop foot on the left and numbness and tingling. He had tenderness over the lower lumbar spine and right PSIS. There was pain at extremes of range of motion. He could not heel or toe walk on the left due to longitudinal arch pain. There was hypersensitivity over the entire left thigh, mid, and plantar foot and decreased sensation over the left lateral calf and dorsum of the foot. Tibialis anterior strength was 3/5 and EHL strength 2/5 on the left. He had lumbar diffuse degenerative changes and mild diffuse degenerative changes of the bilateral feet and ankles. He is status post right sided L5-S1 discectomy in 2001 and a left-sided L4-5 discectomy in 2004. He had revision left-sided L4-5 discectomy and right side L4-5 discectomy on 08/30/13. Acupuncture was recommended along

with medications. On 04/02/2014, he reported low back and radicular symptoms of the left lower extremity to the foot and also to the right buttocks. He reported that his surgery in December 2001 was not successful and he lost control of his left foot with drop foot and additional surgery was recommended. A second surgery in the summer of 2004 was successful and gave him control of his left foot. However he began gradually having left drop foot symptoms again. He had an MRI in November 2012. Low back surgery was recommended. He had increased pain after the surgery as well as increased drop foot symptoms. He had increased pinprick and light touch sensation over the entire left thigh, left medial calf and left plantar foot and it was decreased over the left lateral calf and dorsum of the left foot and intact in the right lower extremity. Tibialis anterior was intact on the right and 3/5 on the left and EHL was intact on the right and 2/5 on the left.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG for Left Lower Extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The history and documentation do not objectively support the request for an EMG of the left lower extremity. The MTUS state "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." In this case, the claimant has obvious neurologic deficits with chronic drop foot. He has no history of a distal leg, ankle, or foot injury and the problem is described as coming from his lumbar spine. It is not clear how the results of this study may change his course of treatment going forward. The request for an EMG is not medically necessary. 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." In this case, the claimant has obvious neurologic deficits with chronic drop foot. He has no history of a distal leg, ankle, or foot injury and the problem is described as coming from his lumbar spine. It is not clear how the results of this study may change his course of treatment going forward. The medical necessity of this request for an EMG has not been demonstrated.

EMG for Right Lower Extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The history and documentation do not objectively support the request for an EMG of the right lower extremity. The MTUS state "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." In this case, the claimant has no obvious neurologic deficits or symptoms of radiculopathy involving the right leg or foot. It is not clear how the results of this study may change his course of treatment going forward. The request for an EMG is not medically necessary. 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." In this case, the claimant has no obvious neurologic deficits or symptoms of radiculopathy involving the right leg or foot. It is not clear how the results of this study may change his course of treatment going forward. The medical necessity of this request for an EMG has not been demonstrated.

NCS for Left Lower Extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation ODG), Low Back, nerve conduction studies

Decision rationale: The history and documentation do not objectively support the request for NCV of the left lower extremity. The MTUS state "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 ODG state "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 also had MRIs and surgery on his lumbar spine and there is no evidence of an injury to his distal leg, ankle, or foot for which this type of study may be indicated, such as peripheral nerve compression or dysfunction. He has already had an MRI and it is not clear how these studies are likely to change his course of treatment. The request for NCV of the left lower extremity EMG is not medically necessary.

NCS for Right Lower Extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Low Back, nerve conduction studies

Decision rationale: The history and documentation do not objectively support the request for NCV of the right lower extremity. The MTUS state "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 ODG state "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 also had MRIs and surgery on his lumbar spine and there is no evidence of an injury to his distal leg, ankle, or foot for which this type of study may be indicated, such as peripheral nerve compression or dysfunction. He has already had an MRI and it is not clear how these studies are likely to change his course of treatment. No ongoing symptoms involving his right leg have been described for which NCV appears to be indicated. The request for NCV of the right lower extremity is not medically necessary.