

Case Number:	CM14-0076141		
Date Assigned:	07/16/2014	Date of Injury:	03/17/2010
Decision Date:	09/16/2014	UR Denial Date:	05/15/2014
Priority:	Standard	Application Received:	05/23/2014

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 Physical Medicine and Rehabilitation 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 injured worker is a 43-year-old male who sustained industrial injuries on March 17, 2010. Following his injury, the injured worker has been treated with pain medications, courses of physical therapy with modalities, home exercises and acupuncture, which only provided him short-term relief of his symptoms. He was declared permanent and stationary since July 8, 2011. Progress report dated February 5, 2014 noted the injured worker's complaints of increased pain, particularly to the left side of his low back. He stated that previously his symptoms were at the right side of the low back, extending along the right hip area. He now has pain in the sacral area extending along the left pelvic crest. There is tenderness to the left lumbosacral junction and over the left posterior superior iliac spines. Just superior to this area, there is edema and exquisite tenderness noted. Tenderness over the sacrum was appreciated. A Magnetic Resonance scan of the lumbar spine dated March 14, 2014 showed right paracentral disc protrusion at L4-L5 has decreased in size compared to the previous exam (February 15, 2013). There remains mild spinal stenosis at this level. There is no evidence of nerve root compression. There is focal central disc protrusion at L5-S1 identified, but without evidence of spinal stenosis. A progress report dated March 20, 2014 indicated that the injured worker's right leg continued to be symptomatic with pain in the left low back, buttock, left hip, and into the inguinal area rated at 8-9/10. He continued to work with restrictions. Examination findings were significant for some pain extending into the left inguinal area. There was tenderness when palpating over the left buttock and down the posterior hamstrings. An Agreed Medical Evaluation report dated April 22, 2014 noted continued low back pain with sensation of numbness and weakness of the left anterolateral thigh. Exam was significant for an antalgic gait on the left, tenderness over the left lateral hip, muscle guarding over the lumbar region, and diminished strength of the back and abdomen. Diffuse weakness graded 4/5 of the bilateral lower extremities and particular

weakness 3+/5 of the left ankle extension and left greater toe extension were noted. Reflex was 1+ at the left ankle. He was diagnosed with chronic derangement of the lumbar spine; L4-L5 and L5-S1 disc pathology. Progress report dated April 25, 2014 noted continued complaints of low back pain. He reported sensation of pinched nerve to his back, extending into both legs. This pain is aggravated with sitting or standing. Exam findings were significant for positive seated straight leg raising test on the right side, right buttock and hip. Straight leg raise test to the right elicited pain into the right hip. Straight leg raise test to the left elicited sensation in the left anterior lateral thigh. Recent progress report dated June 5, 2014 noted increasing pain to the low back and left hip rated at 6/10. Exam findings showed negative seated straight leg raise test, as well as internal and external rotation of the hips were well tolerated in both the seated and supine position. There is no evidence of weakness in hip flexion, knee extension, and heel-and-toe walk. Deep tendon reflexes were intact in the lower extremity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral Lower Extremity NCS QTY2.00: 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): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Electrodiagnostic studies Official Disability Guidelines (ODG), Low Back, Nerve conduction studies.

Decision rationale: The American College of Occupational and Environment Medicine guidelines state that electromyography, including H-reflex tests may help identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. However, the American College of Occupational and Environment Medicine guidelines and Medical Treatment Utilization Schedule Chronic Pain Guidelines do not specifically address nerve conduction velocity studies of the low back. Other evidence-based guidelines indicate that nerve conduction studies are not recommended for low back conditions when the patient is presumed to have symptoms of radiculopathy. The medical records submitted for review indicates the injured worker's continued complaints of low back pain with radiation to the lower extremities. His physical examination found tenderness of the lumbar and left lateral hip region. His recent evaluation as per progress report dated June 5, 2014 indicates he has neurologically good strength and sensation to both lower extremities. However, there is no indication that the treating physician is suspecting peripheral neuropathy, or any other distal nerve entrapment in the bilateral lower extremities as this was not placed as a working diagnosis for the injured worker. As such, there is a lack of documentation indicating significant neuropathology to support the recommendation of nerve conduction study of the bilateral lower extremities. Therefore, it can be concluded that 2 bilateral lower extremity nerve conduction studies are not medically necessary at this time.