

Case Number:	CM14-0080211		
Date Assigned:	07/18/2014	Date of Injury:	02/15/2004
Decision Date:	08/28/2014	UR Denial Date:	05/08/2014
Priority:	Standard	Application Received:	05/30/2014

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 Emergency 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 records made available for review, this is a 74-year-old male with a 2/15/04 date of injury. At the time (5/8/14) of the Decision for an EMG-bilateral lower extremities and Neurodiagnostic studies and NCV-bilateral lower extremities and Neurodiagnostic studies, there is documentation of subjective (persistent low back pain with radiation to the buttocks and legs, associated with numbness and tingling) and objective (positive straight leg raise, hypoesthesia of the L4-S1 dermatomes, weakness of the left extensor hallucis longus and ankle plantar flexors, and decreased Achilles reflex) findings, electrodiagnostic findings (EMG/NCV of the bilateral lower extremities (4/15/04) revealed chronic bilateral L5 and S1 radiculopathy), imaging findings (MRI of the lumbar spine (4/18/14) report revealed bilateral neural foraminal narrowing that effaces the bilateral L4 exiting nerve roots at the L4-5 level and diffuse disc protrusion compressing the thecal sac at the L3-4 level), current diagnoses (multilevel lumbar spondylosis and chronic bilateral L5 and S1 radiculopathy), and treatment to date (chiropractic care, activity modification, and injections). There is no documentation of an interval injury or progressive neurologic findings.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG-bilateral lower extremities and Neurodiagnostic studies: Upheld

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

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, Electrodiagnostic studies Other Medical Treatment Guideline or Medical Evidence: Nerve Conduction Velocity Studies (http://www.aetna.com/cpb/medical/data/500_599/0502.html)

Decision rationale: The MTUS reference to ACOEM guidelines identifies documentation of focal neurologic dysfunction in patients with low back symptoms lasting more than three to four weeks, as criteria necessary to support the medical necessity of electrodiagnostic studies. The ODG identifies documentation of evidence of radiculopathy after 1-month of conservative therapy, as criteria necessary to support the medical necessity of electrodiagnostic studies. Medical Treatment Guideline necessitates documentation of an interval injury or progressive neurologic findings to support the medical necessity of a repeat study. Within the medical information available for review, there is documentation of diagnoses of multilevel lumbar spondylosis and chronic bilateral L5 and S1 radiculopathy. In addition, there is documentation of previous electrodiagnostic studies of the bilateral lower extremities performed on 4/15/04. Furthermore, there is documentation of focal neurologic dysfunction with low back symptoms lasting more than three to four weeks and evidence of radiculopathy after 1-month of conservative therapy. However, despite documentation of subjective (persistent low back pain with radiation to the buttocks and legs, associated with numbness and tingling) and objective (positive straight leg raise, hypoesthesia of the L4-S1 dermatomes, weakness of the left extensor hallucis longus and ankle plantar flexors, and decreased Achilles reflex) findings, and given documentation of a previous EMG/NCV of the bilateral lower extremities identifying chronic bilateral L5 and S1 radiculopathy, there is no documentation of an interval injury or progressive neurologic findings. Therefore, based on guidelines and a review of the evidence, the request for EMG-bilateral lower extremities and Neurodiagnostic studies is not medically necessary.

NCV-bilateral lower extremities and Neurodiagnostic studies: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low back-Lumbar & Thoracic (Acute & Chronic).

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, Electrodiagnostic studies Other Medical Treatment Guideline or Medical Evidence: Nerve Conduction Velocity Studies (http://www.aetna.com/cpb/medical/data/500_599/0502.html)

Decision rationale: The MTUS reference to ACOEM guidelines identifies documentation of focal neurologic dysfunction in patients with low back symptoms lasting more than three to four weeks, as criteria necessary to support the medical necessity of electrodiagnostic studies. The ODG identifies documentation of evidence of radiculopathy after 1-month of conservative therapy, as criteria necessary to support the medical necessity of electrodiagnostic studies. Medical Treatment Guideline necessitates documentation of an interval injury or progressive neurologic findings to support the medical necessity of a repeat study. Within the medical information available for review, there is documentation of diagnoses of multilevel lumbar

spondylosis and chronic bilateral L5 and S1 radiculopathy. In addition, there is documentation of previous electrodiagnostic studies of the bilateral lower extremities performed on 4/15/04. Furthermore, there is documentation of focal neurologic dysfunction with low back symptoms lasting more than three to four weeks and evidence of radiculopathy after 1-month of conservative therapy. However, despite documentation of subjective (persistent low back pain with radiation to the buttocks and legs, associated with numbness and tingling) and objective (positive straight leg raise, hypoesthesia of the L4-S1 dermatomes, weakness of the left extensor hallucis longus and ankle plantar flexors, and decreased Achilles reflex) findings, and given documentation of a previous EMG/NCV of the bilateral lower extremities identifying chronic bilateral L5 and S1 radiculopathy, there is no documentation of an interval injury or progressive neurologic findings. Therefore, based on the guidelines and a review of the evidence, the request for NCV-bilateral lower extremities and Neurodiagnostic studies is not medically necessary.