

Case Number:	CM14-0082882		
Date Assigned:	07/21/2014	Date of Injury:	12/07/1998
Decision Date:	09/17/2014	UR Denial Date:	05/15/2014
Priority:	Standard	Application Received:	06/04/2014

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 Illinois. 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 55 year old male with a reported date of injury on 12/07/1998. The mechanism of injury reportedly occurred while the injured worker was pulling oxygen tanks up the stairs. The diagnoses included lumbosacral spondylosis without myelopathy, lumbosacral sprain/strain, radiculopathy of the lumbar spine, lumbar disc protrusions at L2-3, L3-4, L4-5, L5-S1 and T11-12, and multilevel lumbar degenerative disc disease. He was treated with conservative care following the injury including home use of a TENS unit, epidural steroid injections, traction, chiropractic care, pain clinic, psychology, and acupuncture; TENS, physical therapy, and acupuncture provided relief. The injured worker underwent an MRI of the lumbar spine on 02/24/2010 (unofficial) which showed multilevel disc disease and spondylosis at L5-S1 and L4-5. A CT scan and discogram(s) were also listed but results were not provided. No pertinent surgical history was provided. The injured worker complained of low back and buttock pain throughout the years that had become worse over the last few months. On 02/11/2014, at a pain management visit, he reported that standing, walking and lifting cause his pain to increase and if he walked more than 10 to 15 minutes he had numbness in his left thigh. He also reported that he would wake from sleep with back pain, the pain occasionally radiated into the heels, more on left than right, and the majority of pain was across the low back. The injured worker reported pain of at least 6/10 and 8/10 at the time of the visit, as well as musculoskeletal weakness. The clinician noted the injured worker had pain to palpation bilaterally to the L3-S1 facets and intervertebral spaces, paraspinal muscles were tender to palpation, anterior flexion was noted to be 40 degrees which caused pain, extension of 10 degrees which caused pain, bilateral lateral flexion caused pain. Neurological exam on that date revealed, normal motor strength, and mild hypoesthesia along L5 dermatomes. Deep tendon reflexes were normal. On 03/04/2014, the injured worker reported pain with lumbar motion. The physical exam revealed tenderness to

palpation in the upper, mid, and lower lumbar paravertebral muscles and right sciatic notch. Range of motion revealed 25 degrees of flexion, 20 degrees bilateral lateral bending, 15 degrees right lateral rotation, 20 degrees of left lateral rotation and 10 degrees of extension. The clinician also noted a list with lumbar motion and straight leg raise caused pain to back without nerve irritability. Neurologic exam revealed decreased sensation bilaterally in the L4-5 and L5-S1 dermatomes with mild weakness of the right extensor hallicus longus, posterior tibialis, gastroc soleus and tibialis anterior, mild depression in the right ankle reflex was also noted. Relevant medications included Alprazolam 0.5 mg tablet once daily; Hydrocodone acetaminophen; Diclofenac 50 mg tablet, delayed release, 1 tablet daily as needed; Fexmid; Omeprazole, Cyclobenzaprine, soma, and Orphenadrine citrate (strength and dosage not provided unless indicated). Neurontin caused dizziness and nausea. The request was for bilateral lower extremity Electromyography (EMG) / Nerve Conduction Velocity (NCV). The request for authorization form was submitted for review on 03/04/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

bilateral lower extremity Electromyography (EMG) / Nerve Conduction Velocity (NCV):
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disabilities guidelines.

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, Nerve conduction studies (NCS) & EMGs (electromyography).

Decision rationale: The request for bilateral lower extremity Electromyography (EMG)/Nerve Conduction Velocity (NCV) is not medically necessary. The injured worker was more than 16 years post injury with chronic low back pain with radiculopathy to lower extremities. He was diagnosed with lumbosacral spondylosis without myelopathy, lumbosacral sprain/strain, radiculopathy of the lumbar spine, lumbar disc protrusions at L2-3, L3-4, L4-5, L5-S1 and T11-12, and multilevel lumbar degenerative disc disease. He complained of intermittent pain with worsening symptoms to the lower extremities. The California MTUS/ACOEM guidelines indicate EMG may be useful to identify focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. The Official Disability Guidelines add that EMGs are not necessary if radiculopathy is clinically obvious. The guidelines state NCV is not recommended for patients with radiculopathic symptoms. The injured worker had clinical findings consistent with radiculopathy including decreased sensation bilaterally in the L4-5 and L5-S1 dermatomes with mild weakness of the right extensor hallicus longus, posterior tibialis, gastroc soleus and tibialis anterior, mild depression in the right ankle reflex and a diagnosis of radiculopathy. An MRI was requested at the same visit the EMG/NCV were requested; however, there is a lack of documentation indicating whether the MRI has been requested and whether it was performed. Given the obvious clinical findings indicating neurologic deficit,

electrodiagnostic studies would not be indicated. As such, the request for bilateral lower extremity EMG/NCV is not medically necessary.