

<b>Case Number:</b>	CM14-0085452		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	03/11/2012
<b>Decision Date:</b>	09/08/2014	<b>UR Denial Date:</b>	05/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/09/2014

### 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 submitted documents, this is a 60-year-old woman injured on 3/11/12 with a slip and fall. She sustained injury to her lower back. There is an orthopedic report of 4/23/14 that references that the patient had developed a temporary partial paralysis after an epidural (no date mentioned). At that time she was complaining of significant back pain but her legs were really not too uncomfortable even with walking and standing for prolonged periods. No objective examination was documented. There was concern for hematuria from a recent urinalysis done due to flank pain and she was advised to seek evaluation for that non-industrially. That report stated that the patient had had a recent MRI of the lumbar spine done which showed a multilevel disc protrusion with neural encroachment, especially at L4-5 and L5-S1 with 4-5 mm disc extrusion at L5-S1 level. (That report was not included in the documents for review). Under review was a request for electromyography and nerve conduction velocity studies (EMG/NCV) of the bilateral lower extremity made in a 1/31/14 surgical consultation. That report indicated patient had two LESI's (lumbar epidural steroid injections) and later developed urinary and bowel problems. The report notes that a lumbar fusion had been recommended, scheduled and cancelled reportedly by the insurance company. Objective findings were tenderness in the lumbar spine, the bilateral sciatic notches and right posterior superior iliac spine. There is right-sided decreased sensation at L4, L5 and S1. There is limited range of motion with pain. Diagnosis was L4-5 spondylolisthesis and stenosis. Authorization for updated diagnostic studies including MRI of lumbar spine and EMG/NCV of the bilateral lower extremities was requested. There is a 1/17/14 report from the same orthopedist, who authored the 4/20/14 report, entitled 'Supplemental Medical Legal Report Record Review'. This indicated that a panel QME done by another Dr. on 12/12/13 and also a supplemental report from the PQME was reviewed and that this indicated patient was MMI (maximum medical improvement). This report states that the

patient had previously had a lumbar epidural and following this had significant myelopathy with profound weakness of the lower extremity such that she cannot ambulate without use of a walker, weakness to resistance of plantar and dorsiflexion. There was concern that the patient may require an emergency decompression. However, gradually the patient had improvement in the motor strength. The surgeon who recommended surgery was not part of the network and the decompression recommended was not allowed. A 12/12/13 Orthopedic PQME did not document any abnormal neurologic findings in the lower extremities stating that sensation was intact, reflexes were normal and there was no localized muscle weakness. No atrophy was noted. This also noted an MRI of the lumbar spine on 12/19/12, and an EMG/NCS lumbar spine and lower extremities on 4/8/12 reported normal. Relating to the lower back the diagnosis was multilevel intervertebral lumbar disc syndrome. No additional diagnostic testing was recommended. No surgery was recommended. There is also a supplemental report from this PQME dated 2/27/14 noting lumbar sacral radiographs of 11/20/13 with narrowing of the L5-S1 disc space. An 8/30/12 MRI of lumbar spine which was reported to show this desiccation in the lumbar area, and L2-3 2 9 mm disc bulging (reviewer comment- there is a space between the 2 and the 9 and it is possible a "." is missing.) Bilateral facet hypertrophy and disc desiccation and L5-S1 3.5 mm disc bulge pressing the thecal sac, bilateral facet hypertrophy with neural foraminal narrowing in this desiccation. The reports do not mention any recent conservative treatment other than medications and there is no mention in the documents as to when the patient and the lumbar epidural steroid injection that resulted in the neurologic deficits referenced above.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Electromyography and Nerve Conduction Velocity Studies (EMG/NCV) of the Bilateral Lower Extremity: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Table 12-8, Chronic Pain Treatment Guidelines Low Back Complaints, Knee Complaints, Ankle and Foot Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment for Workers Compensation, Low Back-Lumbar and Thoracic (acute & chronic), EMG's and NCS's.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) lowback, electrodiagnostic testing.

**Decision rationale:** The submitted medical records indicate that there is disagreement between the examining PQME, the orthopedic consultant for back surgery and the general orthopedist who appears to be the primary treating provider (PTP). The PQME examination in November 2013 did not find any neurologic deficits but the surgical consultation in January 2014 describes loss of sensation right L4, L5 and S1. That report did not mention any subjective complaints however. The orthopedists (who has been following the patient) most recent report stated that there was back pain but no leg pain. There is a history of a remote episode of significant neurologic deficit in the extremities in the past but those apparently have resolved. No reports express any concern for peripheral neuropathy. There is mention of ongoing bowel and bladder

complaints but these are not further elaborated on and the patient apparently recently had some type of nonindustrial kidney problem which confounds the issue. ACOEM guidelines indicate that if the patient has not improved after a month that there can be consideration for needle EMG and that H-reflex tests to clarify nerve root dysfunction. NCV is not supported by either ACOEM or ODG for evaluation of lumbar radiculopathy. Taking all this into consideration, the overall current clinical presentation as documented, the available evidence and considering the guidelines, there is no current medical necessity for the requested electrodiagnostic testing of the lower extremities