

Case Number:	CM14-0189627		
Date Assigned:	01/02/2015	Date of Injury:	10/13/2010
Decision Date:	02/05/2015	UR Denial Date:	10/24/2014
Priority:	Standard	Application Received:	11/12/2014

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 Rehab, has a subspecialty in Interventional spine 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 patient is a 55 year old male with an injury date of 10/13/10. Based on the 08/29/14 progress report, the patient complains of pain in the low back down his left leg and numbness in his left leg. He is also having pain in his left shoulder with radicular pin in his arm and hand. There is tenderness of his left shoulder in the acromioclavicular joint, anterior deltoid, and SITS muscles. There is pain with range of motion. According to the 09/25/14 report, the patient complains of constant dull aching with stiffness and spasm. He rates his pain as an 8/10 and has had an increase in neck pain/low back pain in lower extremity. Based on the 10/15/14 report, the patient complains of headaches with nausea, dizziness, and difficulty sleeping. He has constant sharp pain in neck with radiating pain to shoulder, elbow and arm. His low back pain radiates to the bilateral anterior and posterior lower extremity to the feet. The 09/10/14 MRI of the lumbar spine revealed the following: Postsurgical changes are noted at L4-L5 and L5-S1. There is normal alignment. At L3-L4, there is a 1-mm midline disc bulge. There is mild facet arthropathy of the lower lumbar spine. The patient's diagnoses includes the following: Cervicalgia (neck pain) Cervical spine radiculitis/neuritis (nos) Left shoulder impingement syndrome Status post left shoulder surgery Lumbago (pain in lumbar spine) Lumbar spine radiculitis/neuritis (nos) Status post lumbar spine surgery The utilization review determination being challenged is dated 10/24/14. Treatment reports were provided from 04/17/14-10/15/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV of the bilateral lower extremities: 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 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints Page(s): 303, 260-262.

Decision rationale: The patient presents with pain in the lower back which radiates down to his left leg and pain in his left shoulder which radiates to his arm and hands. The request is for EMG/NCV of the Bilateral Lower Extremities. For EMG, ACOEM Guidelines page 303 states "Electromyography, including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks." ODG guidelines under foot/ankle chapter does not discuss electrodiagnostics. ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11, page 260-262 states: "Appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful. NCS and EMG may confirm the diagnosis of CTS but may be normal in early or mild cases of CTS. If the EDS are negative, tests may be repeated later in the course of treatment if symptoms persist." The 10/15/14 report states that there was "an EMG and nerve conduction studies of the low back performed in mid-2013. He does not recall the results or the date of the EMG and nerve conduction studies... He has some severe radiculopathy symptoms radiating down his left leg and to the bottom of his feet. He has ongoing weakness in his legs. He has failed conservative therapy." However, the patient does not present with examination changes. There are no progressive neurologic deficits to warrant repeat electrodiagnostics. The patient already had a set of studies a year ago. The requested EMG/NCV of the bilateral lower extremities is not medically necessary.