

Case Number:	CM14-0193876		
Date Assigned:	12/01/2014	Date of Injury:	06/23/2014
Decision Date:	01/22/2015	UR Denial Date:	11/06/2014
Priority:	Standard	Application Received:	11/19/2014

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:

This is a 50-year-old female with a 6/23/14 date of injury, when she bent her back and knees forward and suddenly developed needle-pricking sensation. The patient was seen on 10/22/14 with complaints of 8/10 constant, sharp and stabbing low back pain, radiating into the buttocks and bilateral legs. The pain was associated with weakness and fatigue in the lower extremities. Exam findings of the lumbar spine revealed spasms and tenderness over the lumbar paraspinals and decreased range of motion. The sensation was intact to light touch and pinprick in the lower extremities, DTRs were 2+ and there was motor weakness in the left lower leg. The SLR test was positive at 70 degrees bilaterally. The progress report stated that an MRI of the lumbar spine was pending. The diagnosis is lumbar sprain/strain with possible disc injury, lumbar radiculopathy, and right lower leg pain. MRI of the lumbar spine dated 8/22/14 revealed multilevel degenerative disease at the L4-L5 and L5-S1 levels with facet and disc disease contributing to neural foraminal narrowing, more on the left side; minimal central canal stenosis at the L5-S1 level due to degenerative changes. Treatment to date: work restrictions, massage, PT, and medications. An adverse determination was received on 11/6/14 for a lack of evidence of lumbar radiculopathy and a lack of an MRI report.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Electromyography and Nerve Conduction studies for the Lower Extremity as an outpatient: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM - [https://www.acoempracguides.org/Low Back, Low Back Disorders](https://www.acoempracguides.org/Low%20Back,%20Low%20Back%20Disorders).

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 Chapter EMG/NCV)

Decision rationale: CA MTUS states that electromyography (EMG), including H-reflex tests, are indicated to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three to four weeks. In addition, ODG states that EMGs may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious. Furthermore, NCS are not recommended when a patient is presumed to have symptoms on the basis of radiculopathy. The progress report dated 10/22/14 indicated that the patient complained of radicular symptoms in the lower extremities. The physical examination revealed that there was motor weakness in the left lower leg, however the muscle group was not specified. An MRI report of the lumbar spine dated 8/22/14 revealed multilevel degenerative disease at the L4-L5 and L5-S1 levels with facet and disc disease contributing to neural foraminal narrowing, more on the left side and minimal central canal stenosis at the L5-S1 level due to degenerative changes. The Guidelines state that EMGs are not necessary if radiculopathy is already clinically obvious and NCS are not recommended when a patient is presumed to have symptoms on the basis of radiculopathy. However, it is not clear, why the request was for bilateral EMG/NCS of the lower extremities given, that the patient's radicular symptoms were documented on the left side only. Therefore, the request for 1 Electromyography and Nerve Conduction studies for the Lower Extremity as an outpatient was not medically necessary.