

Case Number:	CM14-0197612		
Date Assigned:	12/05/2014	Date of Injury:	09/29/1995
Decision Date:	01/22/2015	UR Denial Date:	11/04/2014
Priority:	Standard	Application Received:	11/25/2014

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:

The applicant is a represented [REDACTED] employee who has filed a claim for chronic low back pain reportedly associated with an industrial injury of September 29, 1995. In a Utilization Review Report dated November 4, 2014, the claims administrator failed to approve a request for diagnostic testing of the bilateral lower extremities. The claims administrator cited an October 23, 2014 progress note in its denial. The claims administrator suggested that the applicant already had compelling evidence of lumbar radiculopathy, radiographically confirmed, in his report. In a December 6, 2013 physical medicine consultation, the applicant reported ongoing complaints of low back pain with bilateral lower extremity paresthesia, right greater than left. The applicant was on Naprelan, Lunesta, Tizanidine, and Zocor. The applicant was given a diagnosis of L5-S1 disk injury with associated radiculopathy. The attending provider stated that the applicant had had earlier Electrodiagnostic testing in 2010 and earlier lumbar MRI imaging some two to three years prior. Lumbar MRI imaging of January 6, 2014 was notable for multilevel degenerative changes, moderate spinal canal stenosis at L4-L5 with an associated 3-mm disk bulge with associated bilateral neuroforaminal stenosis, and moderate neuroforaminal stenosis at L5-S1. A right foraminal disk protrusion was noted at L3-L4 with partial effacement of the neural foramen. On October 14, 2014, the applicant reported ongoing complaints of low back pain radiating to the bilateral lower extremities. The applicant was on Naprosyn, Tizanidine, and Lunesta, it was acknowledged. The attending provider noted that the applicant had had earlier lumbar MRI imaging of January 2014 demonstrating a spinal stenosis and a disk bulge at L4-L5. The attending provider suggested the applicant undergo Electrodiagnostic testing. It was stated that earlier Electrodiagnostic testing was notable for a possible left L5 radiculopathy. It was stated that the applicant's symptoms had increased in the setting of the previously referenced lumbar MRI.

Permanent work restrictions were renewed. The applicant's past medical history was not detailed.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCS of the bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 14 Ankle and Foot Complaints Page(s): 309, 377.

Decision rationale: As noted in the MTUS Guideline in ACOEM Chapter 12, Table 12-8, page 309, EMG testing is not recommended for applicants with a clinically obvious radiculopathy. In this case, the applicant does seemingly have a clinically obvious radiculopathy. Earlier MRI imaging of January 6, 2014 did demonstrate evidence of neuroforaminal stenosis, spinal stenosis, and disk bulging at the L4-L5 and L5-S1 levels. Such said findings do seemingly account for the applicant's ongoing lower extremity radicular complaints, as does the prior positive Electrodiagnostic testing of 2010. Similarly, the MTUS Guideline in ACOEM Chapter 14, Table 14-6, page 377 notes that electrical studies are not recommended" for foot and ankle problems without clinical evidence of tarsal tunnel syndrome or other entrapment neuropathies. In this case, however, there was no mention of a tarsal tunnel syndrome, entrapment neuropathy, or compression neuropathy suspected here. Rather, all evidence on file pointed to the applicant's carrying a diagnosis of clinically-evident, radiographically confirmed lumbar radiculopathy. There was no mention of the applicant's having any systemic disease process such as diabetes mellitus, hypothyroidism or alcoholism which would predispose toward development of a lower extremity neuropathy. Since both the EMG and NCS components of the request were not indicated, the request is not medically necessary.