

Case Number:	CM14-0204096		
Date Assigned:	12/16/2014	Date of Injury:	05/30/2010
Decision Date:	02/11/2015	UR Denial Date:	11/05/2014
Priority:	Standard	Application Received:	12/05/2014

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 a filed a claim for chronic low back and knee pain reportedly associated with an industrial injury of May 30, 2010. In a Utilization Review Report dated November 4, 2014, the claims administrator denied electrodiagnostic testing of bilateral lower extremities. Both MTUS and non-MTUS Guidelines were invoked. The claims administrator suggested, however, that MRI imaging of June 2, 2014 demonstrated only minimal abnormalities. A medical-legal evaluation of October 6, 2014 was referenced in the determination. The applicant is reportedly status post an epidural steroid injection, the claims administrator suggested. In an April 30, 2014 progress note, the applicant reported persistent complaints of low back pain radiating to the bilateral legs, 6 to 7/10. The applicant was given an antalgic gait, requiring the usage of a cane. The attending provider alluded to earlier electrodiagnostic testing of November 30, 2014 demonstrating S1 nerve root irritation with ongoing axonal degeneration. Home Health services were sought while the applicant was placed off of work, on total temporary disability. In a progress note dated September 8, 2014, the applicant again reported 6 to 7/10 low back and knee pain. The applicant reported persistent complaints of burning pain about the right leg, exacerbated by standing and walking. The attending provider suggested that the applicant undergo an L5-S1 lumbar fusion surgery. Norco and Neurontin were endorsed while the applicant was placed off of work, on total temporary disability. On October 30, 2014, the applicant reported persistent complaints of low back pain with burning radiation down the left leg on this occasion. The applicant apparently exhibit surgical scars about the lumbar spine, suggesting that the applicant had undergone earlier lumbar spine surgery. Norco was renewed. Lumbar MRI imaging was sought. On October 6, 2014, the applicant underwent a medical-legal evaluation. The medical legal evaluator noted that the applicant had undergone earlier spine surgery on March 7, 2014,

and would remain off of work, on total temporary disability. On June 2, 2014, the applicant reported persistent complaints of low back pain radiating to the bilateral lower extremities. The applicant again exhibited an antalgic gait requiring use of the cane. Positive straight leg raising was noted. Neurosurgical consultation was endorsed while the applicant was placed off of work, on total temporary disability. On June 9, 2014, the applicant's orthopedic surgeon noted the applicant had ongoing complaints of low back pain radiating to the bilateral legs, left greater than right. MRI imaging, per the attending provider, demonstrated "more damage." The attending provider suggested the applicant consider surgical fusion and/or discectomy. Norco was endorsed, while the applicant was kept off of work. The lumbar MRI imaging of June 2, 2014 was notable for a 4-mm disk prominence with granulation tissue at the L5-S1 level generating S1 nerve root subluxation with mild-to-moderate neuroforaminal stenosis. A neurosurgeon noted June 17, 2014 that the applicant had a recurrent L5-S1 disk herniation and suggested that the applicant undergo revision discectomy-foraminotomy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electromyography/Nerve Conduction Velocity (EMG/NCV) of 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, Low Back Chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 14 Ankle and Foot Complaints Page(s): TABLE 12-8, PAGE 309; TABLE 14-6, PAGE 377.

Decision rationale: 1. No, the proposed electrodiagnostic testing of the bilateral lower extremities is not medically necessary, medically appropriate, or indicated here. 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, as is present here. Several spine surgeons have all commented that they believe that applicant has a recurrent disk herniation at L5-S1 noted on MRI imaging of June 2, 2014, and have advocated surgical treatment of the same. Thus, the applicant has a clinically obvious, radiographically-confirmed radiculopathy, which effectively obviates the need for the proposed electrodiagnostic testing. Similarly, the MTUS Guideline in ACOEM Chapter 14, Table 14-6 also notes that electrical studies (AKA nerve conduction testing) are "not recommended" for applicants with routine foot/ankle/leg problems without evidence of tarsal tunnel syndrome or other entrapment neuropathies. Here, as with the EMG component of the request, the applicant, quite clearly, has a clinically-evident, radiographic-confirmed lumbar radiculopathy. There was no mention of tarsal tunnel syndrome, diabetic neuropathy, generalized peripheral neuropathy, etc., being present or suspected here. Therefore, the request was not medically necessary.