

Case Number:	CM14-0208137		
Date Assigned:	12/22/2014	Date of Injury:	08/06/2014
Decision Date:	02/18/2015	UR Denial Date:	12/11/2014
Priority:	Standard	Application Received:	12/12/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabn

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 patient is a 48 year old female with an injury date of 8/06/14. No PR2 was submitted with the treatment request. Based on the 11/11/14 orthopedic spine consultation, this patient complains of "constant, moderate to severe, diffuse low back pain with pain radiating into the bilateral lower extremities posteriorly to the ankles as well as bilateral groin pain." Exam of the lumbar spine is tender to palpation at midline lumbar and lumbosacral junction. Lumbar spine range of motion is actual/normal (in degrees): extension of 10/25, flexion of 45/90, left and right lateral bending of 10/25, right rotation of 20/30, and left rotation of 10/30. Exam shows decreased sensation bilaterally in the L5 distribution with a positive straight leg raise on the left at 30 degrees. Diagnostic impressions for this patient are:1. Left shoulder internal derangement. 2. Mechanical back pain.3. Lumbar radiculopathy. Work status as of 11/11/14: Modified duty work with restrictions. The utilization review being challenged is dated 11/12/14. The request was denied given the lack of "documented sensory, reflex or motor deficits to warrant further investigation with an EMG." The request is for EMG/NCV of the left lower extremity and EMG/NCV of the right lower extremity. The requesting provider has provided two reports from 9/17/14 and 11/11/14, respectively.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV of the left lower extremity: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Low Back Complaints. Decision based on Non-MTUS Citation ODG, Online Edition, Low Back-Lumbar & Thoracic (Acute & Chronic)

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 - Lumbar & Thoracic (Acute & Chronic) Chapter.

Decision rationale: This patient presents with low back and bilateral leg pain. The physician requests EMG/NCV of the left lower extremity, but no PR2 was submitted with the treatment request. The ODG guidelines recommend EMG as an option (needle, not surface), to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. The ACOEM guidelines, page 303, state, "Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks." Per the 11/11/14 report, this patient presents with low back and bilateral leg pain. Lumbar spine examination is normal for weight-bearing, gait, and stance, though with some limited lumbar range of motion. Deep tendon reflexes and pathologic reflexes of the lower extremity are 2+ and equal, and normal bilaterally. While patient is unable to toe/heel walk, exam is normal bilaterally for the Lasegue's sign, Patrick's test, and Waddell's signs. Reviews of submitted documents do not include any diagnostic reports, except for mention of x-rays (date unknown) taken at [REDACTED] shortly after her date of injury. Patient was prescribed medication, attended six sessions of physical therapy (with minimal relief) and then received an injection (though type, location, and date unknown). The 11/11/14 report does note a request for authorization for an MRI of the lumbar spine. ACOEM supports EMG for low back pain to determine subtle focal neurologic dysfunction. This patient has not had an EMG/NCV, and given the patient's low back pain, and radiating symptoms, the request for the EMG/NCV of the left lower extremities is medically necessary.

EMG/NCV of the right lower extremity: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Low Back Complaints. Decision based on Non-MTUS Citation ODG, Online Edition, Low Back-Lumbar & Thoracic (Acute & Chronic)

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 - Lumbar & Thoracic (Acute & Chronic) Chapter.

Decision rationale: This patient presents with low back and bilateral leg pain. The physician requests EMG/NCV of the right lower extremity, but no PR2 was submitted with the treatment request. The ODG guidelines recommend EMG as an option (needle, not surface), to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. The ACOEM guidelines, page 303, state,

"Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks." Per the 11/11/14 report, this patient presents with low back and bilateral leg pain. Lumbar spine examination is normal for weight-bearing, gait, and stance, though with some limited lumbar range of motion. Deep tendon reflexes and pathologic reflexes of the lower extremity are 2+ and equal, and normal bilaterally. While patient is unable to toe/heel walk, exam is normal bilaterally for the Lasegue's sign, Patrick's test, and Waddell's signs. Reviews of submitted documents do not include any diagnostic reports, except for mention of x-rays (date unknown) taken at [REDACTED] shortly after her date of injury. Patient was prescribed medication, attended six sessions of physical therapy (with minimal relief) and then received an injection (though type, location, and date unknown). The 11/11/14 report does note a request for authorization for an MRI of the lumbar spine. ACOEM supports EMG for low back pain to determine subtle focal neurologic dysfunction. This patient has not had an EMG/NCV, and given the patient's low back pain, and radiating symptoms, the request for EMG/NCV of the right lower extremities is medically necessary.