

Case Number:	CM14-0209039		
Date Assigned:	12/22/2014	Date of Injury:	05/25/2001
Decision Date:	02/27/2015	UR Denial Date:	12/01/2014
Priority:	Standard	Application Received:	12/15/2014

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: Texas, Ohio, California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 May 25, 2001. In a Utilization Review Report dated December 1, 2014, the claims administrator denied a request for electrodiagnostic testing of the bilateral lower extremities. The claims administrator noted that the applicant had undergone earlier lumbar fusion surgery and had received epidural steroid injection therapy, acupuncture, TENS unit, physical therapy, and aquatic therapy without seeming benefit as the applicant remained off of work. The claims administrator referenced a progress note dated June 16, 2014, in which it was stated that the applicant was severely obese, with a BMI of 45, along with a subsequent progress note of November 28, 2014. The applicant's attorney subsequently appealed. On June 6, 2014, the applicant reported ongoing complaints of low back pain. The note was very difficult to follow and mingled historical complaints with current complaints. The applicant had reportedly tried and failed a spinal cord stimulator, it was suggested. The applicant exhibited visibly antalgic gait. The applicant was severely obese, with BMI of 45. The applicant was not working. The applicant had been terminated by his former employer, it was incidentally noted. The applicant was described as using crutches to move about, it was stated in one section of the note. The applicant did have a visibly antalgic gait, it was stated. The applicant was depressed, it was further noted. OxyContin and Wellbutrin were endorsed, along with electrodiagnostic testing of the bilateral lower extremities. The applicant did have a history of hypertension, it was incidentally noted. The attending provider suggested that the electrodiagnostic testing at issue could be employed to search for radiculopathy versus

neuropathy. In a November 6, 2014 progress note, the applicant again reported persistent complaints of low back pain. Lyrica was reportedly attenuating the applicant's leg pain. The applicant was considering lumbar medial lumbar branch block, it was noted, and was using Suboxone, it was noted.

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.

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, as appears to be the case here. The applicant has a longstanding history of lumbar radiculopathy and is status post earlier lumbar fusion surgery for the same. The applicant has undergone epidural steroid injections, again for presumed radiculopathy, and continues to use adjuvant medications such as Lyrica, again for presumed radiculopathy. It is not clear how the electrodiagnostic testing at issue would influence or alter the treatment plan as the applicant already appears to carry diagnosis of clinically evident radiculopathy which effectively obviates the need for electrodiagnostic testing here. Similarly, the MTUS Guideline in ACOEM Chapter 14, Table 14-6, page 377 also notes that the routine usage of electrical studies for ankle, foot, and/or leg problems without clinical evidence of tarsal tunnel syndrome or other entrapment neuropathies is "not recommended." Here, there was no mention of a tarsal tunnel syndrome or focal entrapment neuropathy suspected here. While the attending provider stated, in a highly templated manner, that the electrodiagnostic testing at issue was being sought for the purposes of determining the presence or absence of radiculopathy versus neuropathy, nothing about the applicant's history or presentation was suggestive of generalized lower extremity neuropathy or focal compressive neuropathy. The applicant did not carry diagnoses such as hypothyroidism, alcoholism, and/or diabetes which would predispose the applicant toward development of a generalized lower extremity neuropathy. Rather, all evidence on file pointed to the applicant's carrying a diagnosis of clinically obvious radiculopathy for which electrodiagnostic testing is not indicated, per ACOEM Chapter 12, Table 12-8, page 309. Therefore, the request is not medically necessary.