MAXIMUS Federal Services

Case Number:	CM14-0045391		
Date Assigned:	06/27/2014	Date of Injury:	11/25/1997
Decision Date:	04/08/2015	UR Denial Date:	03/12/2014
Priority:	Standard	Application Received:	04/01/2014

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, Indiana, New York
Certification(s)/Specialty: Internal 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 injured worker is a 61 year old female, who sustained an industrial injury reported on 11/25/1997. On 2/26/2014, she reported incapacitating, radiating back pain, right > left, with increased weakness of the right leg; and a new radiating right pelvis area pain, with weakness to the right leg, spasms to the right foot and toes; and left foot and big toe problems. Her previous visit is noted to have been on 12/12/2013. The diagnoses were noted to include chronic pain syndrome; lumbosacral spondylosis without myelopathy; degenerative lumbar disc disease with radiculitis; femoral neuropathy; and lumbar facet syndrome. Treatments to date have included consultations; diagnostic imaging studies; right-sided lumbar facet blocks (2009); right transforaminal epidural steroid injection therapy (3/2010) and left transforaminal epidural steroid injection therapy (5/2013) both with 80% effectiveness; physical therapy; electromyogram and nerve conduction studies of the left lower extremity (2/5/13); and medication management - currently with Norco and Ultram for pain relief. The history notes cardiac side effects from Neurontin, and a 10 year history for taking Oxycontin before being switched to Fentanyl patches that were denied by workman's compensation insurance, so Lyrica was tried and discontinued due to cardiac side effects. Allergies are noted to include Cymbalta, Lyrica, Neurontin and Codeine. The work status classification for this injured worker (IW) was noted to be permanent and stationary. The 3/1/2014 referral notes show the comprehensive body part to be the Disc-Lumbar. On 3/12/2014, Utilization Review (UR) non-certified, for medical necessity, the request, made on 2/26/2014, for an outpatient electromyogram and nerve conduction study of the right lower extremity. The Medical Treatment Utilization Schedule, chronic pain medical

treatment guidelines; the American College of Occupational and Environmental Medicine Guidelines, chapter 12, low back complaints; and table 2, Broadspire's Physician Advisory Criteria for electromyogram and/or nerve conduction Velocity Studies, were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG of the right 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-hhtps://www.acoempracguides.org/Low Back; Table 2, Summary of Recommendations, Low Back Disorders.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-5. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back section, EMG/NCV.

Decision rationale: Pursuant to the Official Disability Guidelines, bilateral lower extremity EMG/NCV studies are not medically necessary. Nerve conduction studies are not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. EMGs may be useful to obtain unequivocal evidence of radiculopathy, after one-month conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious. The ACOEM states unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging if symptoms persist. In this case, the injured worker's working diagnosis of chronic pain syndrome that he: lumbosacral spondylosis myelopathy; and disk displacement with radiculitis lumbar. Subjectively, the injured worker has undergone facet joint injections and epidural steroid injections with some improvement. She has been treated with Neurontin. The injured worker states her right leg is getting weaker and she is having new pain in her right held this area that radiates down the entire right lower extremity. This new pain has been present for approximately 3 weeks (data progress note February 21, 2014). She complains of numbness down the entire right lower extremity of the inside of the lower part of the right leg. She also has a lot of problems with her left foot. Objectively, the neurologic evaluation shows decreased sensation left L5-S1 with decreased in sensation on the right entire leg except for the inside leg. Lower extremity motor exam shows mild weakness the dorsiflexion and plantar flexion. Bilateral hip extension and flexion or weak and equal. The neurologic complaints and evaluation have not changed significantly from prior subjective and objective findings in earlier progress notes. This documentation does not show unequivocal specific nerve compromise on the neurologic evaluation sufficient to warrant EMG/NCV studies. The injured worker appears to have a radiculopathy involving the right lower extremity. There is minimal justification for performing nerve conduction studies when the patient is presumed to have symptoms on the basis of radiculopathy. The date of injury is November 25, 1997. The medical record contains 60 pages. It is unclear whether a prior EMG/NCV was performed based on the date of injury and the duration of treatment to date. Consequently, absent clinical documentation with unequivocal findings to identify specific nerve compromise on the neurologic evaluation in the presence of

what appears to be a right lower extremity radiculopathy with symptoms that are grossly unchanged from prior physical examinations, bilateral lower extremity EMG/NCV studies are not medically necessary.

NCS of the right 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-hhtps://www.acoempracguides.org/Low Back; Table 2, Summary of Recommendations, Low Back Disorders.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-5. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back section, EMG/NCV.

Decision rationale: Pursuant to the Official Disability Guidelines, bilateral lower extremity EMG/NCV studies are not medically necessary. Nerve conduction studies are not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. EMGs may be useful to obtain unequivocal evidence of radiculopathy, after one-month conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious. The ACOEM states unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging if symptoms persist. In this case, the injured worker's working diagnosis of chronic pain syndrome that he: lumbosacral spondylosis myelopathy; and disk displacement with radiculitis lumbar. Subjectively, the injured worker has undergone facet joint injections and epidural steroid injections with some improvement. She has been treated with Neurontin. The injured worker states her right leg is getting weaker and she is having new pain in her right held this area that radiates down the entire right lower extremity. This new pain has been present for approximately 3 weeks (data progress note February 21, 2014). She complains of numbness down the entire right lower extremity of the inside of the lower part of the right leg. She also has a lot of problems with her left foot. Objectively, the neurologic evaluation shows decreased sensation left L5-S1 with decreased in sensation on the right entire leg except for the inside leg. Lower extremity motor exam shows mild weakness the dorsiflexion and plantar flexion. Bilateral hip extension and flexion or weak and equal. The neurologic complaints and evaluation have not changed significantly from prior subjective and objective findings in earlier progress notes. This documentation does not show unequivocal specific nerve compromise on the neurologic evaluation sufficient to warrant EMG/NCV studies. The injured worker appears to have a radiculopathy involving the right lower extremity. There is minimal justification for performing nerve conduction studies when the patient is presumed to have symptoms on the basis of radiculopathy. The date of injury is November 25, 1997. The medical record contains 60 pages. It is unclear whether a prior EMG/NCV was performed based on the date of injury and the duration of treatment to date. Consequently, absent clinical documentation with unequivocal findings to identify specific nerve compromise on the neurologic evaluation in the presence of what appears to be a right lower extremity radiculopathy with symptoms that are grossly unchanged from prior physical examinations, bilateral lower extremity EMG/NCV studies are not medically necessary.