

Case Number:	CM14-0074039		
Date Assigned:	07/16/2014	Date of Injury:	01/31/2012
Decision Date:	02/05/2015	UR Denial Date:	05/19/2014
Priority:	Standard	Application Received:	05/21/2014

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 Neurology, 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 Injured Worker (IW) is a 42 year-old male with a reported date of injury on 1/31/2012. The mechanism of injury is stated that the worker felt a pull in his mid and low back while turning a crank on a manual elevator machine used in lifting a tub of oranges. In Primary Treating Physician Progress Reports (PR-2s) dated 11/4/14, 10/7/14, 9/9/14, 4/9/14, 3/4/14, 1/21/14, 12/16/13 and 12/6/13 it is stated virtually without alteration that the IW complains of burning, radicular mid back pain and muscle spasm aggravated by prolonged positioning including sitting, standing, walking and bending. The pain is aggravated by activities of daily living. These symptoms persist but medications offer temporary relief and assist his ability to have restful sleep. The physical findings in each of these reports are also identical from date to date: there is tenderness to palpation of the thoracic spine with bilateral paraspinal spasm with trigger points noted; the thoracic dermatomes are within normal limits; there is tenderness to palpation of the lumbar paraspinal muscles with trigger points throughout and tenderness to palpation at the bilateral PSISs; the lumbar range of motion is limited in all planes tested; there is bilateral positive straight leg raise at 60-degrees; sensation is intact at L4, L5 and S1 dermatomes bilaterally; motor strength is 5/5 in bilateral lower extremities; deep tendon reflexes are 2+ and symmetrical in the bilateral lower extremities. A thoracic spine MRI obtained on 5/24/14 is unremarkable. Lumbar spine MRI's were obtained on 5/28/14, 11/6/13, 5/3/13 and 4/10/12 and are generally unchanged from study to study with impressions for broad-based disc protrusion producing bilateral neuroforaminal narrowing at L3-4, L4-5 and L5-S1; spinal canal narrowing at L4-5 and L5-S; and evidence for a posterior annular fissures at L3-4 and L4-5. Anatomical Impairment study conducted on 2/28/2014 using radiographs of the lumbar spine yielded normal assessments. Electromyography (EMG) and nerve conduction velocity studies (NCV) were conducted on 5/21/13 and no evidence of entrapment neuropathy in the bilateral lower

extremities was found; no electromyographic indicators of acute lumbar radiculopathy were found. The IW has received physical therapy, acupuncture and numerous compounded medications including Deprizine, Dicopanol, Fanatrex, Synapryn, Tabradol, Capsaicin, Flurbiprofen, Menthol, Cyclobenzaprine and Gabapentin. A request for bilateral EMG/NCV studies was submitted on 5/9/2014 and was subsequently denied on 5/19/2014. An appeal to that decision was filed on 5/21/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electromyography 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 (ODG), Pain chapter, Electrodiagnostic testing EMG/NCS

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303 -304.

Decision rationale: The ACOEM Guidelines, Chapter 12 Low Back Complaints, suggest that electromyography (EMG) studies may be indicated to identify any subtle focal neurologic dysfunction where low back symptoms have persisted more than three or four weeks (Special Studies and Diagnostic and Treatment Considerations, p. 303 - 304). Nerve Conduction Velocity studies are a component of EMG studies and it is not expected that this component of the study would be conducted separately from the EMG study when using electrophysiological diagnostics in the determination of neurological compromise in low back and lower extremity complaints. Such studies may provide the unequivocal objective finding for nerve compromise when a physical exam yields inconsistent or equivocal findings for neural compromise. Further, evidence from such studies may serve as the medical substantiation to warrant imaging studies (i.e., MRI) where surgery may be considered an option after conservative therapies have failed. In this particular case, however, the physical exam findings are consistently absent to report any clinical findings for neurological compromise which might possibly suggest that further investigation through electromyography and nerve conduction velocity studies is necessary. While there is tenderness to palpation and spasm, none of the medical reports provide any clinical evidence to suggest any particular neurological deficit. All neurological clinical exams serially report findings within normal limits. Further, there have been four lumbar spine imaging studies performed in two years' time which may be arguably more sensitive (indeed, false positive findings and diagnostic confusion with indiscriminate imaging studies is a known concern) for findings of neurological compromise: it is unclear what additional information that EMG/NCV studies at this time would provide that would alter the treatment plan. Indeed, EMG/NCV studies conducted on 5/21/2013 (contemporaneously with the imaging study of 5/28/2014) found no evidence for neural entrapment in the bilateral lower extremities and there was no physiological evidence for acute lumbar radiculopathy. As the medical reports fail to substantiate clinical findings for suspected, objective neurological compromise, and since these exam findings have not changed in the time since a previous EMG/NCV study, there is no indication that bilateral lower extremities EMG and NCV studies are medically necessary.

Nerve conduction study 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 (ODG), Pain chapter, Electrodiagnostic testing (EMG/NCS)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303 -304.

Decision rationale: The ACOEM Guidelines, Chapter 12 Low Back Complaints, suggest that electromyography (EMG) studies may be indicated to identify any subtle focal neurologic dysfunction where low back symptoms have persisted more than three or four weeks (Special Studies and Diagnostic and Treatment Considerations, p. 303 - 304). Nerve Conduction Velocity studies are a component of EMG studies and it is not expected that this component of the study would be conducted separately from the EMG study when using electrophysiological diagnostics in the determination of neurological compromise in low back and lower extremity complaints. Such studies may provide the unequivocal objective finding for nerve compromise when a physical exam yields inconsistent or equivocal findings for neural compromise. Further, evidence from such studies may serve as the medical substantiation to warrant imaging studies (i.e., MRI) where surgery may be considered an option after conservative therapies have failed. In this particular case, however, the physical exam findings are consistently absent to report any clinical findings for neurological compromise which might possibly suggest that further investigation through electromyography and nerve conduction velocity studies is necessary. While there is tenderness to palpation and spasm, none of the medical reports provide any clinical evidence to suggest any particular neurological deficit. All neurological clinical exam findings are serially reported as normal. Further, there have been four lumbar spine imaging studies performed in two years' time which may be arguably more sensitive (indeed, false positive findings and diagnostic confusion with indiscriminate imaging studies is a known concern) for findings of neurological compromise: it is unclear what additional information that EMG/NCV studies at this time would provide that would alter the treatment plan. Indeed, EMG/NCV studies conducted on 5/21/2013 (contemporaneously with the imaging study of 5/28/2014) found no evidence for neural entrapment in the bilateral lower extremities and there was no physiological evidence for acute lumbar radiculopathy. As the medical reports fail to substantiate clinical findings for suspected, objective neurological compromise, and since these exam findings have not changed in the time since a previous EMG/NCV study, there is no indication that bilateral lower extremities EMG and NCV studies are medically necessary.