

Case Number:	CM15-0100107		
Date Assigned:	06/02/2015	Date of Injury:	04/22/2014
Decision Date:	07/09/2015	UR Denial Date:	04/24/2015
Priority:	Standard	Application Received:	05/26/2015

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 & Rehabilitation

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 40-year-old female, who sustained an industrial injury on April 22, 2014 while working as a pharmacy supervisor. The mechanism of injury was a slip and fall in which she landed on her left side. The diagnoses have included low back pain, lumbar five-sacral one herniated nucleus pulposus with annular tear, right lower extremity radiculopathy, adjustment disorder, anxiety and depression. Treatment to date has included medications, radiological studies, injections, MRI, physical therapy, transcutaneous electrical nerve stimulation unit, sudomotor functional assessment, medial branch blocks, chiropractic treatments epidural steroid injections and physical therapy. Current documentation dated March 28, 2015 notes that the injured worker reported constant low back pain with radiation to the right lower extremity, with associated numbness and tingling. She also noted anxiety and depression. The pain was rated a six to seven out of ten on the visual analogue scale. Examination of the lumbar spine revealed tenderness to palpation, palpable spasms and a decreased range of motion. A straight leg raise test was positive on the right. Sensation to light touch was decreased in the right lower extremity. The treating physician's plan of care included a request for a nerve conduction velocity study of the right lower extremity, electromyography of the right lower extremity, nerve conduction velocity study of the left lower extremity and electromyography of the left lower extremity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electromyography (EMG) of the Right Lower Extremity: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Lumbar & Thoracic (Acute & Chronic), EMGs (electromyography).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Low Back - Lumbar & Thoracic (Acute & Chronic) chapter, EMGs (electromyography)'Low Back - Lumbar & Thoracic (Acute & Chronic)' and topic 'Nerve conduction studies (NCS).

Decision rationale: The patient presents with low back pain radiating to RIGHT lower extremity rated 6-7/10. The request is for ELECTROMYOGRAPHY (EMG) OF THE RIGHT LOWER EXTREMITY. The request for authorization is not provided. MRI of the lumbar spine, 04/28/15, shows posterior disc bulges of 2 mm at L1-L2 and 3 to 4 mm at L5-S1 where there is an annular fissure in the posterior aspect of the disc and mild midline central canal narrowing. Physical examination reveals tenderness to palpation along the lumbar spine. There are palpable spasms along the paravertebral muscles of the lumbar spine bilaterally. Straight leg raise is positive on the RIGHT and negative on the LEFT. There is decreased sensation to light touch along the L5 to S1 nerve root distribution along the RIGHT lower extremity. She also reports anxiety and depression. The patient denies side effects or GI symptoms with the use of oral and topical medications. Topical creams and patches help decrease pain and use of oral medications, and allow the patient to walk, stand and sleep longer, as well as, perform more chores. Patient's medications include Cyclobenzaprine Hydrochloride, Naproxen Sodium, Omeprazole, Norco and Topical Compounds. Per progress report dated 04/02/15, the patient is temporarily totally disabled. ODG Guidelines, chapter 'Low Back - Lumbar & Thoracic (Acute & Chronic)' and topic 'EMGs (electromyography)', state that EMG studies are "Recommended as an option (needle, not surface). EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 1 month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious." ODG Guidelines, chapter 'Low Back - Lumbar & Thoracic (Acute & Chronic)' and topic 'Nerve conduction studies (NCS)', states that NCV 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. (Utah, 2006) This systematic review and meta-analysis demonstrate that neurological testing procedures have limited overall diagnostic accuracy in detecting disc herniation with suspected radiculopathy." Treater does not discuss the request. In this case, the patient continues with low back pain radiating to RIGHT lower extremity. Given the patient's RIGHT lower extremity symptoms, physical examination findings, and diagnoses, EMG studies would appear reasonable. There is no evidence that this patient has had prior RIGHT lower extremity EMG studies done. Therefore, the request is medically necessary.

Nerve Conduction Velocity (NCV) of the Right Lower Extremity: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Lumbar & Thoracic (Acute & Chronic), Nerve Conduction Studies (NCS).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Low Back - Lumbar & Thoracic (Acute & Chronic) chapter, EMGs (electromyography)'Low Back - Lumbar & Thoracic (Acute & Chronic)' and topic 'Nerve conduction studies (NCS).

Decision rationale: The patient presents with low back pain radiating to RIGHT lower extremity rated 6-7/10. The request is for NERVE CONDUCTION VELOCITY (NCV) OF THE RIGHT LOWER EXTREMITY. The request for authorization is not provided. MRI of the lumbar spine, 04/28/15, shows posterior disc bulges of 2 mm at L1-L2 and 3 to 4 mm at L5-S1 where there is an annular fissure in the posterior aspect of the disc and mild midline central canal narrowing. Physical examination reveals tenderness to palpation along the lumbar spine. There are palpable spasms along the paravertebral muscles of the lumbar spine bilaterally. Straight leg raise is positive on the RIGHT and negative on the LEFT. There is decreased sensation to light touch along the L5 to S1 nerve root distribution along the RIGHT lower extremity. She also reports anxiety and depression. The patient denies side effects or GI symptoms with the use of oral and topical medications. Topical creams and patches help decrease pain and use of oral medications, and allow the patient to walk, stand and sleep longer, as well as, perform more chores. Patient's medications include Cyclobenzaprine Hydrochloride, Naproxen Sodium, Omeprazole, Norco and Topical Compounds. Per progress report dated 04/02/15, the patient is temporarily totally disabled. ODG Guidelines, chapter 'Low Back - Lumbar & Thoracic (Acute & Chronic)' and topic 'EMGs (electromyography)', state that EMG studies are "Recommended as an option (needle, not surface). EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 1month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious." ODG Guidelines, chapter 'Low Back - Lumbar & Thoracic (Acute & Chronic)' and topic 'Nerve conduction studies (NCS)', states that NCV 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. (Utah, 2006) This systematic review and meta-analysis demonstrate that neurological testing procedures have limited overall diagnostic accuracy in detecting disc herniation with suspected radiculopathy." Treater does not discuss the request. In this case, the patient continues with low back pain radiating to RIGHT lower extremity. Given the patient's RIGHT lower extremity symptoms, physical examination findings, and diagnoses, NCV studies would appear reasonable. There is no evidence that this patient has had prior RIGHT lower extremity NCV studies done. Therefore, the request is medically necessary.

Electromyography (EMG) of the Left Lower Extremity: 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, Lumbar & Thoracic (Acute & Chronic), EMGs (electromyography).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Low Back - Lumbar & Thoracic (Acute & Chronic) chapter, EMGs (electromyography)'Low Back - Lumbar & Thoracic (Acute & Chronic)' and topic 'Nerve conduction studies (NCS).

Decision rationale: The patient presents with low back pain radiating to RIGHT lower extremity rated 6-7/10. The request is for ELECTROMYOGRAPHY (EMG) OF THE LEFT LOWER EXTREMITY. The request for authorization is not provided. MRI of the lumbar spine, 04/28/15, shows posterior disc bulges of 2 mm at L1-L2 and 3 to 4 mm at L5-S1 where there is an annular fissure in the posterior aspect of the disc and mild midline central canal narrowing. Physical examination reveals tenderness to palpation along the lumbar spine. There are palpable spasms along the paravertebral muscles of the lumbar spine bilaterally. Straight leg raise is positive on the RIGHT and negative on the LEFT. There is decreased sensation to light touch along the L5 to S1 nerve root distribution along the RIGHT lower extremity. She also reports anxiety and depression. The patient denies side effects or GI symptoms with the use of oral and topical medications. Topical creams and patches help decrease pain and use of oral medications, and allow the patient to walk, stand and sleep longer, as well as, perform more chores. Patient's medications include Cyclobenzaprine Hydrochloride, Naproxen Sodium, Omeprazole, Norco and Topical Compounds. Per progress report dated 04/02/15, the patient is temporarily totally disabled. ODG Guidelines, chapter 'Low Back - Lumbar & Thoracic (Acute & Chronic)' and topic 'EMGs (electromyography)', state that EMG studies are "Recommended as an option (needle, not surface). EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 1 month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious." ODG Guidelines, chapter 'Low Back - Lumbar & Thoracic (Acute & Chronic)' and topic 'Nerve conduction studies (NCS)', states that NCV 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. (Utah, 2006) This systematic review and meta-analysis demonstrate that neurological testing procedures have limited overall diagnostic accuracy in detecting disc herniation with suspected radiculopathy." Treater does not discuss the request. There is no evidence that this patient has had prior LEFT lower extremity EMG studies done. In this case, the patient continues with low back pain radiating to RIGHT lower extremity. Given the patient's lower extremity symptoms, physical examination findings, and diagnoses, EMG studies would appear reasonable. However, the patient's lower extremity symptoms are on the RIGHT side and not on the LEFT. Therefore, the request is not medically necessary.

Nerve Conduction Velocity (NCV) of the Left Lower Extremity: 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, Lumbar & Thoracic (Acute & Chronic), Nerve Conduction Studies (NCS).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Low Back - Lumbar & Thoracic (Acute & Chronic) chapter, EMGs (electromyography)'Low Back - Lumbar & Thoracic (Acute & Chronic)' and topic 'Nerve conduction studies (NCS).

Decision rationale: The patient presents with low back pain radiating to RIGHT lower extremity rated 6-7/10. The request is for NERVE CONDUCTION VELOCITY (NCV) OF THE LEFT LOWER EXTREMITY. The request for authorization is not provided. MRI of the lumbar spine, 04/28/15, shows posterior disc bulges of 2 mm at L1-L2 and 3 to 4 mm at L5-S1 where there is an annular fissure in the posterior aspect of the disc and mild midline central canal narrowing. Physical examination reveals tenderness to palpation along the lumbar spine. There are palpable spasms along the paravertebral muscles of the lumbar spine bilaterally. Straight leg raise is positive on the RIGHT and negative on the LEFT. There is decreased sensation to light touch along the L5 to S1 nerve root distribution along the RIGHT lower extremity. She also reports anxiety and depression. The patient denies side effects or GI symptoms with the use of oral and topical medications. Topical creams and patches help decrease pain and use of oral medications, and allow the patient to walk, stand and sleep longer, as well as, perform more chores. Patient's medications include Cyclobenzaprine Hydrochloride, Naproxen Sodium, Omeprazole, Norco and Topical Compounds. Per progress report dated 04/02/15, the patient is temporarily totally disabled. ODG Guidelines, chapter 'Low Back - Lumbar & Thoracic (Acute & Chronic)' and topic 'EMGs (electromyography)', state that EMG studies are "Recommended as an option (needle, not surface). EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious." ODG Guidelines, chapter 'Low Back - Lumbar & Thoracic (Acute & Chronic)' and topic 'Nerve conduction studies (NCS)', states that NCV 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. (Utah, 2006) This systematic review and meta-analysis demonstrate that neurological testing procedures have limited overall diagnostic accuracy in detecting disc herniation with suspected radiculopathy." Treater does not discuss the request. There is no evidence that this patient has had prior LEFT lower extremity NCV studies done. In this case, the patient continues with low back pain radiating to RIGHT lower extremity. Given the patient's lower extremity symptoms, physical examination findings, and diagnoses, NCV studies would appear reasonable. However, the patient's lower extremity symptoms are on the RIGHT side and not on the LEFT. Therefore, the request is not medically necessary.