

Case Number:	CM15-0017118		
Date Assigned:	02/05/2015	Date of Injury:	07/30/2014
Decision Date:	04/02/2015	UR Denial Date:	01/12/2015
Priority:	Standard	Application Received:	01/29/2015

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 62 year old male, who sustained an industrial injury on July 30, 2014. He has reported a back injury. The diagnoses have included lumbar sprain. Treatment to date has included physical therapy, medications, and radiological imaging. Currently, the IW complains of pain of the lumbar spine with numbness, tingling and radiation into both legs and feet. Physical findings are noted to be tenderness over the lumbar spine, and decreased range of motion. A straight leg raise test is positive on the right. The Utilization Review indicates that a magnetic resonance imaging of the lumbar spine was completed on December 3, 2014, which revealed degenerative changes. On January 12, 2015, Utilization Review non-certified electromyogram of the left lower extremity, and electromyogram of the right lower extremity, and nerve conduction studies of the left lower extremity, and nerve conduction studies of the right lower extremity, based on ODG, MTUS, and ACOEM guidelines. On January 22, 2015, the injured worker submitted an application for IMR for review of electromyogram of the left lower extremity, and electromyogram of the right lower extremity, and nerve conduction studies of the left lower extremity, and nerve conduction studies of the right lower extremity.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG Left Lower Extremity: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official disability guidelines, Low Back chapter on EMG and NCV.

Decision rationale: This patient presents with lumbar spine pain radiating to the bilateral lower extremities with numbness and tingling. The treater is requesting an EMG OF THE LEFT LOWER EXTREMITY. The RFA dated 01/06/2015 shows a request for EMG/NCS of the bilateral lower extremities. The patient's date of injury is from 07/30/2014 and he is currently on modified duty. The ACOEM Guidelines page 303 states that electromyography -EMG- including H-reflex test may be useful to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks. In addition, ODG does not recommend NCV. There is minimal justification for performing nerve conduction studies when the patient is presumed to have symptoms on the basis of radiculopathy. The systemic review and meta-analysis demonstrated neurological testing procedures have limited overall diagnostic accuracy in detecting disk herniation with suspected radiculopathy. In the management of spine trauma with radicular symptoms, EMG/NCS often have low combined sensitivity and specificity in confirming root injury. The 11/21/2014 report shows there is tenderness to palpation over the lumbar spine. Straight leg raise test is positive at 35 degrees with radiation of pain into the right thigh. There is decreased dermatomal sensation noted over the L4-L5 on the right. The patient reports radiation of pain in the bilateral legs to the feet more on the right. The records do not show any previous EMG of the left lower extremity. The MRI of the lumbar spine from 12/03/2014 shows: 1. Multilevel degenerative changes most pronounced at L4-L5 with grade 1 intervertebral listhesis of L4 and L5 secondary to facet arthropathy causing severe dural compression and mild right neuroforaminal stenosis. 2. Degenerative change with right-sided facet arthropathy at T12 to L1 with mild right neuroforaminal stenosis. 3. Degenerative change with a disk bulge measuring 3 mm and bilateral facet arthropathy causing mild dural compression at L1-L2. 4. Disk osteophyte complex measuring 3 mm and bilateral facet arthropathy at L2-L3 causing mild dural compression and moderate left neuroforaminal stenosis. 5. Disk bulge measuring 1 to 2 mm and bilateral facet arthropathy at L3-L4 causing mild dural compression. 6. Disk osteophyte complex measuring 6 mm in bilateral facet arthropathy at L5-S1 causing mild dural compression with bilateral lateral recess narrowing contacting the traversing S1 nerves. Moderate left and mild right neuroforaminal stenosis is also present contacting the exiting left L5 nerve. The exiting L5 nerves are also contacted by the endplate laterally. In this case, given the patient's continued low back symptoms including radiation of pain to the bilateral lower extremities, the request IS medically necessary.

EMG Right Lower Extremity: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official disability guidelines, Low Back chapter on EMG and NCV.

Decision rationale: This patient presents with lumbar spine pain radiating to the bilateral lower extremities with numbness and tingling. The treater is requesting an EMG OF THE RIGHT LOWER EXTREMITY. The RFA dated 01/06/2015 shows a request for EMG/NCS of the bilateral lower extremities. The patient's date of injury is from 07/30/2014 and he is currently on modified duty. The ACOEM Guidelines page 303 states that electromyography -EMG- including H-reflex test may be useful to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks. In addition, ODG does not recommend NCV. There is minimal justification for performing nerve conduction studies when the patient is presumed to have symptoms on the basis of radiculopathy. The systemic review and meta-analysis demonstrated neurological testing procedures have limited overall diagnostic accuracy in detecting disk herniation with suspected radiculopathy. In the management of spine trauma with radicular symptoms, EMG/NCS often have low combined sensitivity and specificity in confirming root injury. The 11/21/2014 report shows there is tenderness to palpation over the lumbar spine. Straight leg raise test is positive at 35 degrees with radiation of pain into the right thigh. There is decreased dermatomal sensation noted over the L4-L5 on the right. The patient reports radiation of pain in the bilateral legs to the feet more on the right. The records do not show any previous EMG of the left lower extremity. The MRI of the lumbar spine from 12/03/2014 shows: 1. Multilevel degenerative changes most pronounced at L4-L5 with grade 1 intervertebral listhesis of L4 and L5 secondary to facet arthropathy causing severe dural compression and mild right neuroforaminal stenosis. 2. Degenerative change with right-sided facet arthropathy at T12 to L1 with mild right neuroforaminal stenosis. 3. Degenerative change with a disk bulge measuring 3 mm and bilateral facet arthropathy causing mild dural compression at L1-L2. 4. Disk osteophyte complex measuring 3 mm and bilateral facet arthropathy at L2-L3 causing mild dural compression and moderate left neuroforaminal stenosis. 5. Disk bulge measuring 1 to 2 mm and bilateral facet arthropathy at L3-L4 causing mild dural compression. 6. Disk osteophyte complex measuring 6 mm in bilateral facet arthropathy at L5-S1 causing mild dural compression with bilateral lateral recess narrowing contacting the traversing S1 nerves. Moderate left and mild right neuroforaminal stenosis is also present contacting the exiting left L5 nerve. The exiting L5 nerves are also contacted by the endplate laterally. In this case, given the patient's continued low back symptoms including radiation of pain to the bilateral lower extremities, the request IS medically necessary.

NCS Left Lower Extremity: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Nerve Conduction Studies.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official disability guidelines, Low Back chapter on EMG and NCV.

Decision rationale: This patient presents with lumbar spine pain radiating to the bilateral lower extremities with numbness and tingling. The treater is requesting an NCS OF THE LEFT LOWER EXTREMITY. The RFA dated 01/06/2015 shows a request for EMG/NCS of the bilateral lower extremities. The patient's date of injury is from 07/30/2014 and he is currently on modified duty. The ACOEM Guidelines page 303 states that electromyography -EMG- including H-reflex test may be useful to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks. In addition, ODG does not recommend NCV. There is minimal justification for performing nerve conduction studies when the patient is presumed to have symptoms on the basis of radiculopathy. The systemic review and meta-analysis demonstrated neurological testing procedures have limited overall diagnostic accuracy in detecting disk herniation with suspected radiculopathy. In the management of spine trauma with radicular symptoms, EMG/NCS often have low combined sensitivity and specificity in confirming root injury. The 11/21/2014 report shows there is tenderness to palpation over the lumbar spine. Straight leg raise test is positive at 35 degrees with radiation of pain into the right thigh. There is decreased dermatomal sensation noted over the L4-L5 on the right. The patient reports radiation of pain in the bilateral legs to the feet more on the right. The records do not show any previous EMG of the left lower extremity. The MRI of the lumbar spine from 12/03/2014 shows: 1. Multilevel degenerative changes most pronounced at L4-L5 with grade 1 intervertebral listhesis of L4 and L5 secondary to facet arthropathy causing severe dural compression and mild right neuroforaminal stenosis. 2. Degenerative change with right-sided facet arthropathy at T12 to L1 with mild right neuroforaminal stenosis. 3. Degenerative change with a disk bulge measuring 3 mm and bilateral facet arthropathy causing mild dural compression at L1-L2. 4. Disk osteophyte complex measuring 3 mm and bilateral facet arthropathy at L2-L3 causing mild dural compression and moderate left neuroforaminal stenosis. 5. Disk bulge measuring 1 to 2 mm and bilateral facet arthropathy at L3-L4 causing mild dural compression. 6. Disk osteophyte complex measuring 6 mm in bilateral facet arthropathy at L5-S1 causing mild dural compression with bilateral lateral recess narrowing contacting the traversing S1 nerves. Moderate left and mild right neuroforaminal stenosis is also present contacting the exiting left L5 nerve. The exiting L5 nerves are also contacted by the endplate laterally. Given neurological and sensory deficits in the lower extremities including radiation of pain from the low back to the bilateral lower extremities, the request IS medically necessary.

NCS Right Lower Extremity: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Nerve Conduction Studies.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official disability guidelines, Low Back chapter on EMG and NCV.

Decision rationale: This patient presents with lumbar spine pain radiating to the bilateral lower extremities with numbness and tingling. The treater is requesting an NCS OF THE RIGHT

LOWER EXTREMITY. The RFA dated 01/06/2015 shows a request for EMG/NCS of the bilateral lower extremities. The patient's date of injury is from 07/30/2014 and he is currently on modified duty. The ACOEM Guidelines page 303 states that electromyography -EMG- including H-reflex test may be useful to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks. In addition, ODG does not recommend NCV. There is minimal justification for performing nerve conduction studies when the patient is presumed to have symptoms on the basis of radiculopathy. The systemic review and meta-analysis demonstrated neurological testing procedures have limited overall diagnostic accuracy in detecting disk herniation with suspected radiculopathy. In the management of spine trauma with radicular symptoms, EMG/NCS often have low combined sensitivity and specificity in confirming root injury. The 11/21/2014 report shows there is tenderness to palpation over the lumbar spine. Straight leg raise test is positive at 35 degrees with radiation of pain into the right thigh. There is decreased dermatomal sensation noted over the L4-L5 on the right. The patient reports radiation of pain in the bilateral legs to the feet more on the right. The records do not show any previous EMG of the left lower extremity. The MRI of the lumbar spine from 12/03/2014 shows: 1. Multilevel degenerative changes most pronounced at L4-L5 with grade 1 intervertebral listhesis of L4 and L5 secondary to facet arthropathy causing severe dural compression and mild right neuroforaminal stenosis. 2. Degenerative change with right-sided facet arthropathy at T12 to L1 with mild right neuroforaminal stenosis. 3. Degenerative change with a disk bulge measuring 3 mm and bilateral facet arthropathy causing mild dural compression at L1-L2. 4. Disk osteophyte complex measuring 3 mm and bilateral facet arthropathy at L2-L3 causing mild dural compression and moderate left neuroforaminal stenosis. 5. Disk bulge measuring 1 to 2 mm and bilateral facet arthropathy at L3-L4 causing mild dural compression. 6. Disk osteophyte complex measuring 6 mm in bilateral facet arthropathy at L5-S1 causing mild dural compression with bilateral lateral recess narrowing contacting the traversing S1 nerves. Moderate left and mild right neuroforaminal stenosis is also present contacting the exiting left L5 nerve. The exiting L5 nerves are also contacted by the endplate laterally. Given neurological and sensory deficits in the lower extremities including radiation of pain from the low back to the bilateral lower extremities, the request IS medically necessary.