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| Case Number: | CM15-0131924 | | |
| Date Assigned: | 07/20/2015 | Date of Injury: | 10/14/2013 |
| Decision Date: | 08/19/2015 | UR Denial Date: | 06/08/2015 |
| Priority: | Standard | Application Received: | 07/08/2015 |

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: Texas, California

Certification(s)/Specialty: Family Practice

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 was a 41-year-old female, who sustained an industrial injury, October 14, 2013. The injured worker previously received the following treatments functional capacity evaluation, chiropractic services, physical therapy and acupuncture. The injured worker was diagnosed with cervicgia, cervical strain/sprain, thoracic pain, thoracic strain/sprain, left gluteus medius/maximus sprain/strain and low back pain syndrome, lumbalgia, degenerative disc disease at L5-S1 with disc herniation with stenosis of the spinal cord, left lower extremity radiculopathy and myofascitis. The injured worker was breast-feeding. According to progress note of April 30, 2015, the injured worker's chief complaint was neck and back pain. The pain was rated at 5-6 out of 10. The pain was made worse by repetitive bending, lifting or prolonged head positions. The physical exam noted trigger points in the thoracic paraspinal. The deep tendon reflexes were normal in the upper extremities. The sensory and motor testing was normal in the upper extremities. There was tenderness at the thoracolumbar paravertebral muscles with muscle spasms at the quadratus lumborum. The sensory and motor exam to the lower extremities was normal. There was a full squat with full recovery; however, there was reproduced pain. There was decreased thoracic range of motion. The treatment plan included EMG/NCS (electrodiagnostic studies and nerve conduction studies) of the bilateral lower extremities. The patient has had MRI of the lumbar spine on 6/9/14 that revealed disc protrusions, foraminal narrowing, and degenerative changes and EMG study of lower extremity on March 2014 that was normal. Per the note dated 5/18/15, the patient had complaints of pain in neck and low back with radiation and numbness and tingling at 6/10. Physical examination of the low back revealed normal gait and difficulty in rising from sitting. The current medication list was not specified in the records specified.

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 Page(s): 303.

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

Decision rationale: Request EMG/NCV of the bilateral lower extremities. Per ACOEM chapter 12 guidelines, "Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks." Per the ACOEM guidelines cited below, "For most patients presenting with true neck or upper back problems, special studies are not needed unless a three- or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out, Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks." The patient has had MRI of the lumbar spine on 6/9/14 that revealed disc protrusions, foraminal narrowing, and degenerative changes and EMG study of lower extremities was done on March 2014 that was normal. Any significant changes in objective physical examination findings since the last electro diagnostic study that would require a repeat electro diagnostic study were not specified in the records provided. The sensory and motor exam to the lower extremities was normal. Any significant functional deficits on physical examination that would require EMG/NCV of the bilateral lower extremities was not specified in the records provided. The patient had received an unspecified number of the PT visits for this injury. The records submitted contain no accompanying current PT evaluation for this patient. A detailed response to a complete course of conservative therapy including PT visits was not specified in the records provided. Previous PT visit notes were not specified in the records provided. The response of the symptoms to a period of rest and oral pharmacotherapy was not specified in the records provided. The medical necessity of the request for EMG/NCV of the bilateral lower extremities is not fully established for this patient. Therefore, the request is not medically necessary.