

Case Number:	CM15-0137937		
Date Assigned:	07/27/2015	Date of Injury:	01/20/2015
Decision Date:	08/24/2015	UR Denial Date:	07/01/2015
Priority:	Standard	Application Received:	07/16/2015

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: Emergency 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 40 year-old female who sustained an industrial injury to her lower back on 01/20/2015 when pulling a box from an overhead stack. The injured worker was diagnosed with lumbar spine sprain/strain and a 10mm lumbar disc herniation with radiculopathy. Treatment to date has included diagnostic testing with recent lumbar spine magnetic resonance imaging (MRI) in April 2015, conservative measures, lumbar epidural steroid injection, physical therapy and medications. According to the primary treating physician's progress report on June 4, 2015, the injured worker continues to experience low back pain radiating to the right buttock, leg, foot and toes. The injured worker rates her pain level at 7-8/10. The injured worker also reports anxiety, depression and insomnia. Examination of the lumbar spine demonstrated tightness and spasm of the paraspinal muscles. There was no tenderness at the posterior/superior spine, sciatic notch or sciatic nerve areas. Range of motion was noted at 35 degrees flexion and bilateral lateral bending at 20 degrees each. Lasegue's was positive bilaterally. Straight leg raise was positive at 50 degrees on the right and 70 degrees on the left with pain in the L5-S1 dermatome distribution. There was hypoesthesia at the anterolateral aspect of the foot and ankle of an incomplete nature at L5 and S1 dermatome levels on the right. Weakness in the big toe dorsiflexors, plantar flexors, evertors and extensors on the right was documented at 3/5. Deep tendon reflexes were 1+ bilaterally with absent ankle reflex on the right. Right facet joint tenderness at L3, L4 and L5 was noted. Sacroiliac (SI) joints, hips and inguinal areas were within normal limits. Current medication is Hydrocodone. Treatment plan consists of discogram and

the current request for Electromyography (EMG)/Nerve Conduction Velocity (NCV) studies of the bilateral lower extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV Bilateral Lower Extremities: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter.

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

Decision rationale: The requested EMG/NCV Bilateral Lower Extremities, is medically necessary. American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 12, Low Back Complaints, page 303, Special Studies and Diagnostic and Treatment Considerations, note "Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study." The injured worker has low back pain radiating to the right buttock, leg, foot and toes. The injured worker rates her pain level at 7-8/10. The injured worker also reports anxiety, depression and insomnia. Examination of the lumbar spine demonstrated tightness and spasm of the paraspinal muscles. There was no tenderness at the posterior/superior spine, sciatic notch or sciatic nerve areas. Range of motion was noted at 35 degrees flexion and bilateral lateral bending at 20 degrees each. Lasegue's was positive bilaterally. Straight leg raise was positive at 50 degrees on the right and 70 degrees on the left with pain in the L5-S1 dermatome distribution. There was hypoesthesia at the anterolateral aspect of the foot and ankle of an incomplete nature at L5 and S1 dermatome levels on the right. Weakness in the big toe dorsiflexors, plantar flexors, evertors and extensors on the right was documented at 3/5. Deep tendon reflexes were 1+ bilaterally with absent ankle reflex on the right. Right facet joint tenderness at L3, L4 and L5 was noted. Sacroiliac (SI) joints, hips and inguinal areas were within normal limits. The treating physician has documented positive neurologic exam findings and persistent radicular pain and paresthesias despite therapy trials. The criteria noted above having been met, EMG/NCV Bilateral Lower Extremities is medically necessary.