

Case Number:	CM15-0138742		
Date Assigned:	07/28/2015	Date of Injury:	05/08/2008
Decision Date:	09/22/2015	UR Denial Date:	07/14/2015
Priority:	Standard	Application Received:	07/17/2015

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: North Carolina

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 is a 62 year old male, who sustained an industrial injury on May 08, 2008. Medical records provided by the treating physician did not indicate the injured worker's mechanism of injury. The injured worker was diagnosed as having herniated cervical disc, left elbow lateral epicondylitis, insomnia, lumbar sprain and strain with disc lesion with radiculitis and radiculopathy, status post four epidural injections to the lumbar spine, positive discogram, right and left sacroiliitis, and anxiety and depression. Treatment and diagnostic studies to date has included chiropractic therapy, medication regimen, physical therapy, acupuncture, magnetic resonance imaging, electromyogram with nerve conduction study, and above noted procedures and studies. In a progress note dated May 22, 2015 the treating physician reports complaints of pain to the low back with radiculopathy to the left leg along with pain to the neck with radiculopathy to the bilateral upper extremities. Examination reveals decreased range of motion to the lumbar spine, positive straight leg raises bilaterally, tightness and spasms to the lumbar paraspinal muscles, hypoesthesia to the anterior lateral region of the foot and ankle at the lumbar five and sacral one bilateral dermatomes, and weakness to the big toe with range of motion. The treating physician noted prior magnetic resonance imaging of an unknown date that was revealing for degenerative disc disease to the lumbar spine with herniated nucleus pulposus at the lumbar three to four and lumbar four to five levels. The treating physician also noted that electromyogram with nerve conduction study of an unknown date revealed radicular evidence. The treating physician requested electromyogram with nerve conduction velocity of the bilateral lower extremities to further assess for nerve injury.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV of right 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.

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

Decision rationale: The ACOEM chapters on low back complaints and the need for lower extremity EMG/NCV states: 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. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures). 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. There are unequivocal objective findings of nerve compromise on the neurologic exam provided for review. However there is not mention of surgical consideration. There are no unclear neurologic findings on exam. For these reasons, criteria for lower extremity EMG/NCV have not been met as set forth in the ACOEM. Therefore the request is not medically necessary.

EMG/NCV of left lower extremity: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back-Lumbar & Thoracic (Acute & Chronic).

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

Decision rationale: The ACOEM chapters on low back complaints and the need for lower extremity EMG/NCV states: 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. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not

warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures). 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. There are unequivocal objective findings of nerve compromise on the neurologic exam provided for review. However there is not mention of surgical consideration. There are no unclear neurologic findings on exam. For these reasons, criteria for lower extremity EMG/NCV have not been met as set forth in the ACOEM. Therefore the request is not medically necessary.