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| Case Number: | CM15-0166607 | | |
| Date Assigned: | 09/04/2015 | Date of Injury: | 05/26/2014 |
| Decision Date: | 10/08/2015 | UR Denial Date: | 08/14/2015 |
| Priority: | Standard | Application Received: | 08/25/2015 |

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, Hawaii
 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 43 year old male who sustained an industrial injury on 5-26-14. The mechanism of injury was a twisting of his body, especially the low back up to the neck with immediate right ankle pain and he felt something popped in the lower back. Diagnoses are lumbar strain, cervical strain, right knee strain, and left paracentral disc protrusion L4-L5. In a progress report dated 8-10-15, the primary treating physician notes continued complaints of low back pain, worse with walking and standing for long periods and bending. Pain radiates up the spine to the neck and there is pain in the right knee, ankle and heel. The pain is rated at a level of 9 out of 10. Pain is improved with Naproxen. Cervical spine range of motion is mildly decreased with pain at the limit of his range. He arises from sitting to standing slowly, but without difficulty. His gait is normal. Lumbar range of motion is moderately decreased with pain at the limit of his range. Motor and sensory function of the lower extremities is intact. Work status is that he is precluded from lifting greater than 10 pounds and repetitive bending and stooping. Previous treatment includes physical therapy, Ibuprofen, Tramadol, and a lumbar MRI. The treatment plan is to continue physical therapy for the right knee, facet injections at bilateral L4-L5 and L5-S1, and refill Naproxen. The requested treatment is electrodiagnostic studies for the bilateral lower extremity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electrodiagnostic Studies for the Bilateral 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), EMGs; NCS.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, EMGs (electromyography).

Decision rationale: The patient presents with diagnoses that include lumbar strain, cervical strain, right knee strain and left paracentral disc protrusion l4-l5. Currently the patient complains of low back pain, pain that radiates up the spine to the neck, pain in the right knee, ankle and heel. The current request is for Electrodiagnostic Studies for the Bilateral Lower Extremity. The treating physician states in the treating report dated 8/10/15 (15b), "He underwent a Qualified Medical Examination who recommended electrodiagnostic studies. The physician goes on to note, "Pain radiates up the spine to the neck." In the treating report dated 7/29/15 (34b) the treating physician documents, "I request authorization for electrodiagnostic studies the bilateral lower extremities to evaluate for radiculopathy or other sources of his persistent leg pain." ACOEM Guidelines allow for EMG studies with H-reflex test to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than 3-4 weeks. ODG states the following regarding EMG studies, "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." In this case, the treating physician notes the failure of conservative care in that the patient's symptoms have not improved. There is also no indication that prior EMG/NCV testing has been provided. Given the patient's continued complaints of radiating pain, further diagnostic testing may be useful to obtain unequivocal evidence of radiculopathy. The current request is medically necessary.