

<b>Case Number:</b>	CM15-0187446		
<b>Date Assigned:</b>	09/29/2015	<b>Date of Injury:</b>	10/13/2008
<b>Decision Date:</b>	11/06/2015	<b>UR Denial Date:</b>	08/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/23/2015

### 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: Arizona, 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 45 year old female injured worker suffered an industrial injury on 10-13-2008. The diagnoses included lumbar post partial laminectomy, herniated lumbosacral spine and ongoing bilateral neuropathic leg pain. On 8-21-2015 the treating provider reported increased back pain and lower extremity symptoms with lower extremity increased sensitivity and burning pain down the left leg. She reported the low back symptoms were still improved from the rhizotomy on 5- 15-2015. She had EMG/NCS bilateral lower extremities on 8-14-2015. On exam she had tenderness of the lumbar spine with spasms, decreased sensation of right lumbar and left lumbar dermatomes. The Patellar and Achilles reflexes were hyporeflexive bilaterally and positive facet provocations test. Prior treatment included physical therapy, chiropractic therapy, transforaminal epidural steroid injections, nerve blocks and medications. Diagnostics included 8-14-2015 EMG/ NCS bilateral lower extremities revealed suggestion of active on chronic right sacroiliac radiculopathy and chronic left sacroiliac radiculopathy. Request for Authorization date was 7-24-2015 was for Electromyography studies/NCV and 8-21-2015 for Follow up with pain management. The Utilization Review on 8-28-2015 determined non-certification for EMG/NCS bilateral lower extremities and Follow up with pain management.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**EMG/NCS bilateral lower extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Summary.

**Decision rationale:** According to the guidelines, an EMG is recommended to clarify nerve root dysfunction in cases of suspected disk herniation preoperatively or before epidural injection. It is not recommended for the diagnoses of nerve root involvement if history and physical exam, and imaging are consistent. An NCV is not recommended to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but recommended if the EMG is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely based on the clinical exam. In this case, the claimant had a herniated nucleus pulposus and facet arthropathy as well as neural foraminal narrowing on MRI of L2-L4. The claimant had persistent decreased sensation in the L5 dermatome and right calf straight leg raise. The claimant's history, exam and imaging are consistent with symptoms. The request for an EMG/ NCV is not medically necessary.

**Follow up with pain management:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter and pg 92.

**Decision rationale:** According to the guidelines, office visits are recommended as medically necessary. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. A specialist referral may be made if the diagnosis is uncertain, extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A consultation is used to aid in diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or examinees fitness for return to work. In this case, a new pain management consultation was made due to the claimant's old pain doctor was no longer seeing patients. However, there was no indication for additional intervention to require a pain management consultation. The referral was only to establish another doctor relation. The request for the consult is not medically necessary at this time.