

Case Number:	CM15-0198781		
Date Assigned:	10/14/2015	Date of Injury:	12/03/2014
Decision Date:	11/20/2015	UR Denial Date:	09/25/2015
Priority:	Standard	Application Received:	10/09/2015

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 47 year old female, who sustained an industrial injury on 12-03-2014. The injured worker was being treated for lumbar disc displacement and radiculopathy. Treatment to date has included diagnostics, physical therapy, and medications. On 7-23-2015, the injured worker complains of continuous left shoulder pain and continuous pain on the low back, with pain radiating to the bilateral lower extremities to the feet (left greater than right). Pain was accompanied by numbness, tingling, and burning sensation and varied throughout the day, rated 5 out of 10. She denied bowel or bladder problems. Current medication use included Ibuprofen. Exam of the lumbar spine noted tenderness to palpation over the lower segment, particularly the mid aspect of the lumbar spine at L4-5 and L5-S1 level and also the left paravertebral region. She had positive straight leg raise on the left side. Range of motion of the lumbar spine was limited by pain. Magnetic resonance imaging of the lumbar spine (3-12-2015) was documented to show "mild degenerative changes of the lumbar spine from L3-L4 through L5-S1" and "evidence of multi disc bulges of 2- to 3-mm in size from L3 through L5 level; however, neural foraminal appears to be patent". Work status was modified with restrictions. The PR2 report (6-25-2015) noted an exam showing diffuse tenderness to palpation in the lumbar spine and diminished light touch sensation to the lateral shin and anterior foot of the left lower extremity. The current treatment plan included electromyogram and nerve conduction studies of the bilateral lower extremities, non-certified by Utilization Review on 9-25-2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electromyograph (EMG) and nerve conduction velocity (NCV) of the 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, EMGs (electromyography), and Nerve conduction studies (NCS).

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

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.