

Case Number:	CM15-0199750		
Date Assigned:	10/14/2015	Date of Injury:	07/06/2015
Decision Date:	11/23/2015	UR Denial Date:	09/22/2015
Priority:	Standard	Application Received:	10/12/2015

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:

This injured worker is a 53 year old male who reported an industrial injury on 7-6-2015. His diagnoses, and or impressions, were noted to include: lumbar spine strain; muscle spasms lower back; thoracic spine myofascial pain; myalgia; lumbosacral musculoligamentous sprain-strain with radiculitis; rule-out lumbar spine discogenic disease; and industrially-caused hypertension, sleep disturbance and depression (situational). No imaging studies were noted. His treatments were noted to include: an agreed medical evaluation date of 9-3-2015 with no report noted; a noted 9 lumbar physical therapy sessions (7-2015); heat-cold therapy; lumbar support; orthopedic consultation; intramuscular Toradol injection; medication management with toxicology studies (10-8-15); and modified work duties before taken off work. The progress notes of 9-8-2015 reported: headaches; back pain; left hip-pelvis pain; calf pain; as well as depression, anxiety, stress, and sleeping problems. The objective findings were noted to include: an antalgic gait favoring the left lower extremity; the appearance of depression; tenderness to the lumbar spine, bilateral para-spinal muscles, bilateral sacroiliac joint, bilateral sciatic notches, bilateral posterior iliac crests, and bilateral gluteal muscles; spasms to the bilateral para-spinal and gluteal muscles; decreased range-of-motion; positive left straight leg raise; pain with heel-toe walking; decreased left knee-ankle deep tendon reflexes with decreased left lower extremity motor strength; and decreased sensation to the left thigh, anterolateral leg, mid-dorsal foot, posterior leg, and lateral foot. The physician's requests for treatment were noted to include electromyogram and nerve conduction velocity studies of the lower extremities. The Request for Authorization, dated 9-3-2015, was noted to include electromyogram and nerve conduction velocity studies bilateral lower extremities. The Utilization Review of 9-22-2015 non-certified the request for electromyography and nerve conduction velocity studies to 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 of the bilateral lower extremities: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Lumbar : EDS.

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.