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| Case Number: | CM15-0200415 | | |
| Date Assigned: | 10/15/2015 | Date of Injury: | 05/27/2009 |
| Decision Date: | 12/04/2015 | UR Denial Date: | 09/23/2015 |
| Priority: | Standard | Application Received: | 10/13/2015 |

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 55 year old female who sustained an industrial injury on 05-27-2009. According to the most recent progress report submitted for review and dated 08-19-2015, the injured worker was seen for neck and low back pain. She continued to have increased pain with Savella. She was trying to increase it up to 25 mg which "seemed to be helping with her neck pain". She was currently off work secondary to a recent car accident that aggravated all of her pain. Norco was helping to keep the pain level tolerable. Chiropractic care also helped. Physical examination demonstrated positive straight leg raise into both legs. Patrick's and facet loading tests were positive. Spurling's test was noted to be positive into the right arm. Sensation was decreased to light touch in the right fifth digit and right ankle. Strength was within normal limits in the bilateral upper and lower extremities. There was tenderness to palpation noted over the cervical paraspinal musculature, upper trapezius, scapular border, lumbar paraspinal musculature and bilateral greater trochanteric bursa. The provider referenced MRI results of the lumbar spine performed on 01-03-2015 which showed degenerative disc protrusion and stenosis. Electrodiagnostic studies performed in February 2013 showed mixed motor sensory median nerve carpal tunnel at the wrist with some changes of chronic EMG (electromyography) signals of right sided C7 plus or minus C8 radiculopathy on the right side. Diagnostic impression included cervicgia, cervical radiculopathy, cervical disc protrusion, lumbago, lumbar radiculopathy, lumbar disc protrusion, lumbar facet dysfunction, degenerative disc disease, insomnia, carpal tunnel syndrome, anxiety, depression and headaches. The treatment plan included lumbar and cervical epidural injection and EMG (electromyography) and NCV (nerve

conduction velocity) studies of the bilateral upper and lower extremities. Follow up was indicated in 4 weeks. An authorization request dated 08-19-2015 was submitted for review. The requested services included cervical epidural steroid injection at C7-T1 level with fluoroscopy, lumbar epidural steroid injection at L5-S1 level with fluoroscopy and EMG-NCS of both upper and lower extremities. On 09-23-2015, Utilization Review non-certified the request for EMG-NCS of the right lower extremity related to the lumbar spine injury as outpatient.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCS of the right lower extremity related to the lumbar spine injury as outpatient:

Upheld

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004.

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.