

Case Number:	CM15-0202117		
Date Assigned:	11/10/2015	Date of Injury:	05/04/2012
Decision Date:	12/21/2015	UR Denial Date:	09/14/2015
Priority:	Standard	Application Received:	10/14/2015

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: Florida
 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 male, who sustained an industrial injury on 5-4-12. The injured worker was diagnosed as having lumbar intervertebral disc displacement and radiculopathy; groin pain, sexual dysfunction; sleep disorder. Treatment to date has included physical therapy; acupuncture; medications. Diagnostics studies included MRI lumbar spine (6-18-15). Currently, the PR-2 notes dated 7-24-15 indicated the injured worker presented for a follow-up visit. The injured worker complains of burning, radicular low back pain and muscle spasms. The provider documents "he rates his pain as 4-5 out of 10, on a pain analog scale. His pain is described as frequent to constant, moderate to severe. The pain is associated with radiculating pain, numbness and tingling of the bilateral lower extremities. The pain is aggravated by prolonged positioning including sitting, standing, walking, bending, arising from a sitting position, ascending or descending stairs, and stooping. The patient has pain in the right groin area. He rates the pain as 5-6 out of 10 on a pain analog scale." The injured worker reports his medications do offer him temporary relief and improve his ability to have restful sleep. He reports the pain is also relieved by activity restrictions. On physical examination, the provider documents "The patient is able to heel-toe walk; however, he has pain with heel walking. Toe touch causes low back pain with the fingers at about 6 inches from the ground. He is able to squat to approximately 40% of normal due to pain in the low back. Palpable tenderness with spasms is noted at the lumbar paraspinal muscles and over at the spinous process L2- to L5." He notes decreased range of motion bilaterally with positive straight leg raise to 45 degrees bilaterally. Sensation to pin prick and light touch is slightly diminished over the L4, L5 and S1

dermatomes bilaterally. Motor strength is noted as slightly decreased secondary to pain in the bilateral lower extremities. Deep tendon reflexes are 2+, Achilles 2+ and vascular pulses are 2+ and symmetrical in the bilateral lower extremities. The treatment plan includes a request for an orthopedic consult for the lumbar spine, undergo a course of acupuncture and physical therapy for the lumbar spine, a lumbar back brace and EMG-NCV of the lower extremities. PR-2 notes dated 6-25-15 were same to similar complaints and treatment plan with the exception of a new request on 7-24-15 of the EMG-NCV study. A MRI of the lumbar spine with Flex-Ext dated 6-18-15 reveals "Disc desiccation L3-L4 down to L5-S1; Modic type II end plate degenerative changes L3-S1; restricted range of motion on flexion -extension; Schmorl's node L4-L5; diffuse disc herniation at most levels. A Request for Authorization is dated 10-14-15. A Utilization Review letter is dated 9-14-15 and modified the certification for Electromyograph (EMG) and nerve conduction velocity (NCV) of bilateral lower extremities to allow the EMG portion of the request only for the bilateral lower extremities. Utilization Review denied the NCV study for the bilateral lower extremities. A request for authorization has been received for EMG-NCV study bilateral lower extremities.

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 bilateral lower extremities: Overturned

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, EMGs (electromyography), Nerve conduction studies (NCS).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG 2015 Online Edition. EMG/NCS.

Decision rationale: MTUS guidelines do not specifically address this request, and therefore the ODG was referenced. The ODG states the following regarding criteria for EMG/NCS studies: Minimum Standards for electrodiagnostic studies: The American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) recommends the following minimum standards: (1) EDX testing should be medically indicated. (2) Testing should be performed using EDX equipment that provides assessment of all parameters of the recorded signals. Studies performed with devices designed only for "screening purposes" rather than diagnosis are not acceptable. (3) The number of tests performed should be the minimum needed to establish an accurate diagnosis. (4) NCSs (Nerve conduction studies) should be either (a) performed directly by a physician or (b) performed by a trained individual under the direct supervision of a physician. Direct supervision means that the physician is in close physical proximity to the EDX laboratory while testing is underway, is immediately available to provide the trained individual with assistance and direction, and is responsible for selecting the appropriate NCSs to be performed. (5) EMGs (Electromyography - needle not surface) must be performed by a physician specially trained in electrodiagnostic medicine, as these tests are simultaneously performed and interpreted. (6) It is appropriate for only 1 attending physician to perform or supervise all of the components of the electrodiagnostic testing (e.g., history taking, physical evaluation, supervision

and/or performance of the electrodiagnostic test, and interpretation) for a given patient and for all the testing to occur on the same date of service. The reporting of NCS and EMG study results should be integrated into a unifying diagnostic impression. (7) In contrast, dissociation of NCS and EMG results into separate reports is inappropriate unless specifically explained by the physician. Performance and/or interpretation of NCSs separately from that of the needle EMG component of the test should clearly be the exception (e.g. when testing an acute nerve injury) rather than an established practice pattern for a given practitioner. Regarding this patient's case, a bilateral lower extremity EMG/NCS is being requested. This patient has been having symptoms that may be consistent with bilateral lower extremity radiculopathy on physical exam, and the requesting physician understandably wishes to confirm this suspicion. Oddly, utilization review did not approve the NCS portion of this study, but did approve the EMG portion. This is odd because traditionally this test is a combined EMG/NCS study. There is no indication to deny the requesting physician in this case both portions of the exam. As the ODG states "dissociation of NCS and EMG results into separate reports is inappropriate unless specifically explained by the physician. Performance and/or interpretation of NCSs separately from that of the needle EMG component of the test should clearly be the exception (e.g. when testing an acute nerve injury) rather than an established practice pattern for a given practitioner." This request for a bilateral EMG/NCS study is medically necessary and appropriate, and utilization review's decision is over turned.