

<b>Case Number:</b>	CM15-0218333		
<b>Date Assigned:</b>	11/10/2015	<b>Date of Injury:</b>	09/11/2014
<b>Decision Date:</b>	12/29/2015	<b>UR Denial Date:</b>	10/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/05/2015

### 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: Texas, 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 injured worker is a 48 year old female who sustained an industrial injury on September 11, 2015. The worker is being treated for: lumbar strain and sprain with multilevel disc disease, facet disease and neural foraminal narrowing; chronic symptomatic lumbar spondylosis with radiculitis. Subjective: May 14, 2015 she reported her symptoms have not changed significantly, and she will continue HEP. August 04, 2015 she reported the injection feels as if it is wearing off and she is still with residual left shoulder pain. August 25, 2015 she reported complaint of lumbar spine pain with radiation to the right lower extremity. Objective: May 14, 2015 noted dorsolumbar spine flexion at 80 degrees, bilateral bending at 20 degrees; able to heel toe walk and motor strength WNL. August 04, 2015 noted left shoulder with healed arthroscopic incisions. Left shoulder ROM noted: forward flexion 160 degrees, abduction 150 degrees, bilateral rotation 70 degrees and internal rotation to T10. The following tests found positive: RTC left Neer's, Hawkin's and Jobe's. August 25, 2015 noted lumbar spine with moderate tenderness about the right and left paralumbar muscles; SLR right reproduces back and right thigh pain and noted positive at 70 degrees. There is note of slight decreased sensation of bilateral posterolateral thigh's and calves. September 22, 2015 she reported not working as the employer does not have any modified work available. She reported current complaints of with persistent lumbar pain that radiates into the right lower extremity at 3-8/10. There is a note of intermittent radiation of pain into the posterolateral thigh and calf. September 22, 2015 noted lumbar spine with persistent tenderness about the right and left paralumbar muscles; SLR on the right reproduced back and right thigh pain positive at 70 degrees. There is noted slight decreased sensation about the posterolateral thigh and posterolateral calf on the right. MRI of the lumbar spine performed on February 04, 2015 revealed disc protrusions, foraminal narrowing. Medications included

Naproxen and Omeprazole in August 2015 and Ibuprofen/anti-inflammatory medication and Omeprazole on September 22, 2015. Treatment: May 2015 POC noted authorization received for pain management pending scheduling; HEP, activity modification: September POC noted requesting acupuncture session, and EMG testing of bilateral lower extremities: August 2015 POC noted completed postoperative course of PT but with residual left shoulder pain, administration of subacromial cortisone injection June 23, 2015 which "provided significant relief of her left shoulder pain," and noted recent "further PT authorized, pending scheduling." On October 23, 2015 a request was made for EMG NCV testing bilateral lower extremities that was non-certified by Utilization Review on October 29, 2015. The patient had received an unspecified number of PT visits for this injury.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **EMG/NCV bilateral lower extremities: Overturned**

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

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

**Decision rationale:** Per ACOEM chapter 12 guidelines, "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." Per the ACOEM guidelines cited below, "For most patients presenting with true neck or upper back problems, special studies are not needed unless a three or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out." Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks." The patient had diagnoses of lumbar strain and sprain with multilevel disc disease, facet disease and neural foraminal narrowing; chronic symptomatic lumbar spondylosis with radiculitis. She reported current complaint of with persistent lumbar pain that radiates into the right lower extremity at 3-8/10. There is a note of intermittent radiation of pain into the posterolateral thigh and calf. On September 22, 2015 it was noted on examination of the lumbar spine that there was persistent tenderness about the right and left paralumbar muscles; SLR on the right reproduced back and right thigh pain positive at 70 degrees. There is noted slight decreased sensation about the posterolateral thigh and posterolateral calf on the right. The patient has chronic pain with significant objective abnormal findings suggestive of possible lumbar radiculopathy. The patient has already had conservative treatment. Electrodiagnostic studies would help to clarify the exact cause of the neurological symptoms and also would help to identify the level at which nerve root impingement may be occurring. This information would guide further management. The request of EMG/NCV bilateral lower extremities is medically necessary and appropriate in this patient to further evaluate the symptoms and signs suggestive of possible radiculopathy.