

Case Number:	CM15-0220478		
Date Assigned:	11/13/2015	Date of Injury:	06/10/2005
Decision Date:	12/23/2015	UR Denial Date:	10/21/2015
Priority:	Standard	Application Received:	11/09/2015

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: California, Indiana, New York
 Certification(s)/Specialty: Internal Medicine

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 63 year old male who sustained an industrial injury on 06-10-2005. According to a consultation report dated 07-23-2015, chief complaints included upper-mid back and lower back. Pain in the upper-mid bilateral back was continuous and characterized as sharp. Lower back pain radiated to the bilateral buttocks and the bilateral thighs. Pain was continuous and characterized as sharp and numbing. Examination of the upper back and lower back demonstrated tenderness and spasms over the bilateral paravertebral regions. Range of motion was decreased with forward flexion, extension, and right and left lateral rotation and right and left bending. Unilateral straight leg raise was positive. Bilateral straight leg raise was positive at greater than 70%. 90-90 straight leg raise and Well straight leg raise was positive. Diagnoses included thoracic radiculopathy, lumbar radiculopathy and left sciatica. Work status included modified work duty. Recommended treatments included physical therapy, lumbar support, Norflex, Anaprox and Prilosec, consultation with a chiropractor, orthopedist and pain management, MRI of the lumbar spine, NCV-EMG (nerve conduction velocity-electromyography) studies of the lower extremities and SPF NCS of the thoracic spine and lumbar spine. MRI of the lumbar spine performed on 08-27-2015 demonstrated Grade 1 anterolisthesis of L4 over L5, disc desiccation with associated loss of disc height at all lumbar levels, Modic type II end plate degenerative changes at L4-5 and L5-S1, straightening of the lumbar lordotic curvature, lumbar levoscoliosis, L1-L2 diffuse disc herniation which abuts the thecal sac, concurrent hypertrophy of bilateral facets ligamentum flava noted, disc material and facet hypertrophy cause narrowing of the bilateral neural foramen - disc measurement 2.7 mm, L2-L3 diffuse disc herniation which abuts the thecal sac, concurrent hypertrophy of bilateral facets ligamentum flava noted, disc material and facet hypertrophy cause narrowing of the

bilateral neural foramen - disc measurement 2.7 mm, L3-4 diffuse disc herniation which abuts the thecal sac, concurrent hypertrophy of bilateral facets ligamentum flava noted, disc material and facet hypertrophy cause narrowing of the bilateral neural foramen with contact on the bilateral L3 exiting nerve roots - disc measurement 2.7 mm, L4-L5 diffuse disc herniation which causes spinal canal stenosis. There was associated narrowing of the bilateral lateral recess, concurrent hypertrophy of bilateral facets and ligamentum flava noted, disc material and facet hypertrophy cause narrowing of the bilateral neural foramen with contact on the bilateral L4 exiting nerve roots - disc measurement 8.0, L5-S1 diffuse disc herniation which abuts the thecal sac, concurrent hypertrophy of bilateral facets ligamentum flava noted, disc material and facet hypertrophy cause narrowing of the bilateral neural foramen - disc measurement 2.7 mm. On 10- 21-2015, Utilization Review non-certified the request for electromyogram-nerve conduction study bilateral lower extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electromyogram/Nerve conduction study bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back section, EMG/NCV.

Decision rationale: Pursuant to the ACOEM and Official Disability Guidelines, Electromyogram / nerve conduction study bilateral lower extremities (EMG/NCS) bilateral lower extremities are not medically necessary. Nerve conduction studies are not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. EMGs may be useful to obtain unequivocal evidence of radiculopathy, after one month conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious. The ACOEM states unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging if symptoms persist. In this case, the injured workers working diagnoses are thoracic radiculopathy; lumbar radiculopathy; and left sciatica. Date of injury is June 10, 2005. Request for authorization is dated July 24, 2015 with a receipt date of October 15, 2015. There is one progress note and the entire medical record. According to the initial consultation dated July 23, 2015, the subject of chief complaint is upper mid and low back pain with radiation to the buttocks and thighs. Objectively, there is tenderness and spasm in the upper back and lower back. Range of motion is decreased and there is positive straight like raising. Motor function is 5/5, DTRs are normal and there is decreased sensation from L2 - S1. There is no description of the type of sensation loss documented. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Based on clinical information in the medical record, peer-reviewed evidence-based guidelines and minimal justification for performing nerve conduction studies when the patient is presumed to have symptoms on the basis of radiculopathy, electromyogram/nerve conduction study bilateral lower extremities (EMG/NCS) bilateral lower extremities are not medically necessary.