MAXIMUS Federal Services

Case Number:	CM15-0085164		
Date Assigned:	05/08/2015	Date of Injury:	07/24/2013
Decision Date:	06/08/2015	UR Denial Date:	04/27/2015
Priority:	Standard	Application Received:	05/05/2015

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: 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 58 year old male, who sustained an industrial/work injury on 7/24/13. He reported initial complaints of pain in the neck and low back along with sciatica. The injured worker was diagnosed as having cervical strain/sprain, cervical spasm, lumbar sprain/strain, sciatica, and lumbar degenerative joint disease. Treatment to date has included medication, brace and transforaminal epidural steroid injections on 2//2014. MRI results were reported on 11/4/13 demonstrated at L5-S1 there is a 4 mm right central disc protrusion with mild lateral recess stenosis, at L4-5 a 2 mm broad based disc bulge, focal 3-4 mm disc protrusion in the far lateral right neural foramen impressing on the right L4 nerve root, moderate degenerative facet seen, L3-4 borderline spinal stenosis . cervical MRI revealed a 2 mm broad based disc bulge at C3-4, at C5-6 a 4 mm broad based disc protrusion, effacing the thecal sac and slightly compressed the spinal cord, and moderately severe bilateral neural foraminal narrowing seen. Electromyography and nerve conduction velocity test (EMG/NCV) was performed on 2/23/15 reported benign EMG of the lower extremities, no motor root impingement no evidence of motor polyneuropathy findings. Currently, the injured worker complains of constant pain in the neck with numbness and tingling in the fingers and occasional headaches. There was also constant pain in the lower back which had improved with numbness in the left foot and occasional burning in the toes. Per the primary physician's progress report (PR-2) on 4/2/15, examination revealed tenderness over the bilateral trapezial and parascapular trigger point regions bilaterally especially on the left. There is limited range of motion of the cervical spine, forward flexes of 30 degrees, extension is limited to 20 degrees, left lateral bending is 10 degrees, and rotation is 55 to the right and 40 to

the left. There is no focal neurological deficit, C4-T1, to motor and sensory evaluation on the right, on the left, there is mild weakness of his bicep, deltoid, and wrist extensor. There is focal tenderness along the biceps tendon groove, and supraspinatus deltoid complex, and the rotator cuff region of his left shoulder. The requested treatments include Electromyogram (EMG) of 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 of the Bilateral Lower Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Low back section, EMG.

Decision rationale: Pursuant to the Official Disability Guidelines, bilateral lower extremity EMG studies 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 identifies specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging if symptoms persist. In this case, the injured worker's working diagnoses are cervical degenerative disc disease; cervical spinal stenosis: left C6 - C7 cervical radiculopathy; lumbar degenerative this disease at L4 - L5 and L5 - S1; lumbar spinal stenosis; and left L5 radiculopathy by clinical examination. The documentation shows the injured worker had an EMG of the right lower extremity February 23, 2015. The results showed a benign EMG of the right lower extremity. According to an April 2, 2015 progress note, the injured worker was complaining of left lower extremity radicular pain. Subjectively, the injured worker complains of constant pain in the low back, which has improved, that radiates into his left leg described as being sciatic pain. Objectively, (neurologically) there are no focal neurologic deficits L2-3 S1 to motor and sensory evaluation on the right. On the left, he has weakness in his EHL, gastrosoleus and peroneal. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. The injured worker had an EMG of the right lower extremity approximately 5 weeks prior. There is no clinical indication to repeat an EMG of the right lower extremity with results that were normal. Consequently, absent compelling clinical documentation support repeating a normal EMG of the right lower extremity, bilateral lower extremity EMG studies are not medically necessary.