

Case Number:	CM13-0060902		
Date Assigned:	12/30/2013	Date of Injury:	06/13/2013
Decision Date:	02/11/2014	UR Denial Date:	11/18/2013
Priority:	Expedited	Application Received:	12/04/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 22 year-old male sustained an injury on 6/13/13 while employed by [REDACTED]. Requests under consideration include URGENT EMG and NCS of the Left and Right Lower Extremities. Report of 10/16/13 from [REDACTED], [REDACTED] the patient complained of persistent and increased pain and stiffness to the lumbar spine that radiated down the legs with numbness and tingling to the lower extremities, worse on right. Exam of the lumbar spine noted the patient ambulated with antalgic gait on the right; TTP over the para-axial musculature with spasticity; lumbar range was limited (flexion 36, extension 14, right bending 18, and left bending 15 degrees); SLR positive on right at 40 degrees and left at 60 degrees; Lasegue's positive on right; sciatic notch pressure painful on right; EHL, EDL and tibialis anterior strength were 3/5 on the right and 5/5 on the left; Patellar and Achilles reflexes were trace on right and 2+ on left; sensation over the L4 and L5 nerve roots on right was decreased. The patient was placed on TTD with recommendation for pain management consultation, possible lumbar epidural steroid injections and EMG and nerve studies of the lower extremities. Diagnoses included lumbar spine sprain/strain; significant disc protrusion at L4-L5 with right lateral recess, right neural foraminal and central canal stenosis and clinical bilateral lower extremity worse on the right. MRI report of 8/8/13 revealed diffuse disc bulge at L3-L4 with superimposed posterior and right paracentral 5 mm disc protrusion at L4-L5, disc desiccation, indentation of the ventral thecal sac, moderate to high grade right lateral recess narrowing, mild right neural foraminal narrowing, moderate central canal narrowing and mild facet and ligamentum flavum hypertrophy with minimal disc bulge at L5-S1. Request for Urgent EMG and NCV of the bilateral lower extremity was non-certified on 11/18/13, citing guidelines criteria and lack of medical necessity

IMR ISSUES, DECISIONS AND RATIONALES

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

URGENT EMG LEFT LOWER EXTREMITY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 308-310.
Decision based on Non-MTUS Citation ODG Low Back, EMGs

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

Decision rationale: This 22 year-old male sustained an injury on 6/13/13 while employed by [REDACTED]. Report of 10/16/13 from [REDACTED], [REDACTED] the patient complained of persistent and increased pain and stiffness to the lumbar spine that radiated down the legs with numbness and tingling to the lower extremities, worse on right. Exam of the lumbar spine noted the patient ambulated with antalgic gait on the right; TTP over the para-axial musculature with spasticity; lumbar range was limited (flexion 36, extension 14, right bending 18, and left bending 15 degrees); SLR positive on right at 40 degrees and left at 60 degrees; Lasegue's positive on right; sciatic notch pressure painful on right; EHL, EDL and tibialis anterior strength were 3/5 on the right and 5/5 on the left; Patellar and Achilles reflexes were trace on right and 2+ on left; sensation over the L4 and L5 nerve roots on right was decreased. Diagnoses included lumbar spine sprain/strain; significant disc protrusion at L4-L5 with right lateral recess, right neural foraminal and central canal stenosis and clinical bilateral lower extremity worse on the right. MRI report of 8/8/13 revealed diffuse disc bulge at L3-L4 with superimposed posterior and right paracentral 5 mm disc protrusion at L4-L5, disc desiccation, indentation of the ventral thecal sac, moderate to high grade right lateral recess narrowing, mild right neural foraminal narrowing, moderate central canal narrowing and mild facet and ligamentum flavum hypertrophy with minimal disc bulge at L5-S1. Submitted reports have not demonstrated any symptoms or clinical findings to suggest any lumbar radiculopathy or entrapment syndrome of the left lower extremity correlating with any remarkable imaging findings of left disc protrusion. The motor strength and sensation were intact in the left lower extremity per report from Dr. Rabinovich. There is no specific consistent myotomal or dermatomal correlation to support for electrodiagnostics for the left lower extremity. The URGENT EMG LEFT LOWER EXTREMITY is not medically necessary and appropriate.

URGENT NCS RIGHT LOWER EXTREMITY: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back, Nerve Conduction Studies (NCS).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

Decision rationale: This 22 year-old male sustained an injury on 6/13/13 while employed by Archway Insurance Co. LTD. Report of 10/16/13 from [REDACTED], [REDACTED]

██████████ has diagnoses to include lumbar spine sprain/strain; significant disc protrusion at L4-L5 with right lateral recess, right neural foraminal and central canal stenosis and clinical bilateral lower extremity worse on the right. Submitted reports have not demonstrated any symptoms or clinical findings to suggest any lumbar polyneuropathy as presumed diagnoses included lumbar spine sprain/strain; significant disc protrusion at L4-L5 with right lateral recess, right neural foraminal and central canal stenosis and clinical bilateral lower extremity worse on the right. Per Guidelines, NCS is not recommended as there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. (Utah, 2006). The URGENT NCS RIGHT LOWER EXTREMITY is not medically necessary and appropriate.

URGENT NCS LEFT LOWER EXTREMITY: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back, Nerve Conduction Studies (NCS).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

Decision rationale: This 22 year-old male sustained an injury on 6/13/13 while employed by ██████████. Report of 10/16/13 from ██████████ the patient complained of persistent and increased pain and stiffness to the lumbar spine that radiated down the legs with numbness and tingling to the lower extremities, worse on right. Exam of the lumbar spine noted the patient ambulated with antalgic gait on the right; EHL, EDL and tibialis anterior strength were 3/5 on the right and 5/5 on the left; Patellar and Achilles reflexes were trace on right and 2+ on left; sensation over the L4 and L5 nerve roots on right was decreased. Diagnoses included lumbar spine sprain/strain; significant disc protrusion at L4-L5 with right lateral recess, right neural foraminal and central canal stenosis and clinical bilateral lower extremity worse on the right. MRI report of 8/8/13 revealed diffuse disc bulge at L3-L4 with superimposed posterior and right paracentral 5 mm disc protrusion at L4-L5, disc desiccation, indentation of the ventral thecal sac, moderate to high grade right lateral recess narrowing, mild right neural foraminal narrowing, moderate central canal narrowing and mild facet and ligamentum flavum hypertrophy with minimal disc bulge at L5-S1. Submitted reports have not demonstrated any symptoms or clinical findings to suggest any lumbar radiculopathy or entrapment syndrome of the left lower extremity correlating with any remarkable imaging findings of left disc protrusion. The motor strength and sensation were intact in the left lower extremity per report from Dr. Rabinovich. The URGENT NCS LEFT LOWER EXTREMITY is not medically necessary and appropriate.

URGENT EMG RIGHT LOWER EXTREMITY: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 308-310. Decision based on Non-MTUS Citation ODG Low Back, EMGs

Decision rationale: This 22 year-old male sustained an injury on 6/13/13 while employed by [REDACTED]. Report of 10/16/13 from [REDACTED], [REDACTED], the patient complained of persistent and increased pain and stiffness to the lumbar spine that radiated down the legs with numbness and tingling to the lower extremities, worse on right. Exam of the lumbar spine noted the patient ambulated with antalgic gait on the right; TTP over the para-axial musculature with spasticity; lumbar range was limited (flexion 36, extension 14, right bending 18, and left bending 15 degrees); SLR positive on right at 40 degrees and left at 60 degrees; Lasegue's positive on right; sciatic notch pressure painful on right; EHL, EDL and tibialis anterior strength were 3/5 on the right and 5/5 on the left; Patellar and Achilles reflexes were trace on right and 2+ on left; sensation over the L4 and L5 nerve roots on right was decreased. Diagnoses included lumbar spine sprain/strain; significant disc protrusion at L4-L5 with right lateral recess, right neural foraminal and central canal stenosis and clinical bilateral lower extremity worse on the right. MRI report of 8/8/13 revealed diffuse disc bulge at L3-L4 with superimposed posterior and right paracentral 5 mm disc protrusion at L4-L5, disc desiccation, indentation of the ventral thecal sac, moderate to high grade right lateral recess narrowing, mild right neural foraminal narrowing, moderate central canal narrowing and mild facet and ligamentum flavum hypertrophy with minimal disc bulge at L5-S1. Submitted reports have demonstrated symptoms and clinical findings to suggest lumbar radiculopathy on the right lower extremity correlating with remarkable imaging findings of right disc protrusion with canal and neural foraminal stenosis. Electrodiagnostic studies of needle EMG is recommended where an MRI has evidence of possible nerve compromise and there are ongoing pain complaints that raise questions about leg symptoms and clinical findings consistent with radiculopathy which has been demonstrated here. The URGENT EMG RIGHT LOWER EXTREMITY is medically necessary and appropriate.