

Case Number:	CM14-0142444		
Date Assigned:	09/10/2014	Date of Injury:	03/24/2005
Decision Date:	01/27/2015	UR Denial Date:	08/25/2014
Priority:	Standard	Application Received:	09/03/2014

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. The expert reviewer is Board Certified in Physical Medicine Rehab, has a subspecialty in Pain Medicine, 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 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/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:

The injured worker is a 55 year-old male, who was injured on March 24, 2005, while performing regular work duties. The injured worker is a transit bus driver. The mechanism of injury is due to being physically assaulted by three juveniles. The injured worker was punched in the nose, and tackled to the floor, resulting in an injury of the lower back. An evaluation on March 13, 2014, indicates the injured worker failed conservative measures of medications and physical therapy; however these records are not available for this review. The evaluation on March 13, 2014, also, indicates the injured worker received epidural steroid injections, and an "X stop" lumbar surgery. These records are not available for this review. The records indicate the injured worker is not currently working. Current medications are indicated to be Ibuprofen, Excedrin, Aspirin, Celebrex, Lisinopril, Metformin HCL ER, Gabapentin, Tramadol, and Novolog Mix 70-30 Flexpen. The record of March 13, 2014 notes several radiological imaging, which are not available for this review. On physical examination on March 13, 2014, the lumbar spine range of motion is noted to be restricted with flexion limited to 50 degrees, extension 25 degrees; there is spasm and tenderness on both sides. The diagnoses given are lumbar facet syndrome, lumbar radiculopathy, and post lumbar laminectomy syndrome, depression, erectile dysfunction, and urinary incontinence. The request for authorization is for electromyogram of lumbar, and electromyogram of bilateral lower extremities. The primary diagnosis is lumbago. On August 25, 2014, Utilization Review non-certified the request for electromyogram of lumbar, and electromyogram of bilateral lower extremities, based on ACOEM, MTUS, and ODG guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, EMG's

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Electrodiagnostic Studies

Decision rationale: Regarding the request for electrodiagnostic study, ACOEM Practice Guidelines state that unequivocal objective findings that identify specific nerve compromise on the neurologic exam are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery. When a neurologic examination is less clear however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. The guidelines further specify that electromyography may be useful to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than 3 to 4 weeks. The electromyogram of the lumbar spine can identify spontaneous activity that can help corroborate a lumbar radiculopathy diagnosis. Within the documentation available for review, there is a full neurologic examination documenting abnormalities in the sensory and deep tendon reflex systems to support a diagnosis of specific nerve compromise. This is documented in a note on date of service 3/13/2014. However, there is no submission of note which documents the need for electrodiagnostic studies at this juncture. The progress note request for a lumbar MRI, but the official radiologist report of the MRI lumbar spine is not available. Furthermore, the utilization review has documented a prior electrodiagnostic study on 1/23/13, but there is a lack of adequate discussion of those results and how the patient's pathology has changed over time. Given this, the currently requested electromyography of the lumbar spine is not medically necessary.

EMG of bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Electrodiagnostic Studies

Decision rationale: Regarding the request for electrodiagnostic study of the lower extremities, ACOEM Practice Guidelines state that unequivocal objective findings that identify specific nerve compromise on the neurologic exam are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery. When a neurologic examination is less clear however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. The guidelines further specify that electromyography may be useful to identify subtle focal neurologic dysfunction in patients with low back

symptoms lasting more than 3 to 4 weeks. Within the documentation available for review, there is a full neurologic examination documenting abnormalities in the sensory and deep tendon reflex systems to support a diagnosis of specific nerve compromise. This is documented in a note on date of service 3/13/2014. However, there is no submission of note which documents the need for electrodiagnostic studies at this juncture. The progress note request for a lumbar MRI, but the official radiologist report of the MRI lumbar spine is not available. Furthermore, the utilization review has documented a prior electrodiagnostic study on 1/23/13, but there is a lack of adequate discussion of those results and how the patient's pathology has changed over time. Given this, the currently requested electromyography of bilateral lower extremities is not medically necessary.