

<b>Case Number:</b>	CM14-0193016		
<b>Date Assigned:</b>	11/26/2014	<b>Date of Injury:</b>	06/05/2013
<b>Decision Date:</b>	01/16/2015	<b>UR Denial Date:</b>	11/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/18/2014

### 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 Occupational 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 applicant is a represented [REDACTED] employee who has filed a claim for chronic mid back, low back and hip pain reportedly associated with an industrial injury of June 5, 2013. Thus far, the applicant has been treated with the following: Analgesic medications; transfer of care to and from various providers in various specialties; unspecified amounts of physical therapy; opioid therapy; and extensive periods of time off of work. In a Utilization Review Report dated November 6, 2014, the claims administrator failed to approve a request for electrodiagnostic testing of lower extremities. The claims administrator stated that its decision was based on an October 7, 2014 progress note. The claims administrator's clinical summary was sparse, although the claims administrator did suggest that the applicant had issues with paresthesias about the right leg and positive straight leg raising on the same. In a December 31, 2013 case management note, the applicant's case manager acknowledged that the applicant was represented and was not working. On September 18, 2014, the applicant reported persistent complaints of low back pain, right hip pain, and mid back pain. The applicant exhibited hyposensorium about the lower extremities, right greater than left in the L5-S1 distribution. The applicant exhibited a slightly antalgic gait. Six sessions of physical therapy and a rather proscriptive 10-pound lifting limitation were endorsed, effectively resulting in the applicant's removal from the workplace. On August 7, 2014, the applicant again reported ongoing complaints of low back pain radiating to the bilateral lower extremities. Hyposensorium was appreciated about the same, right greater than left, in the L5-S1 distribution. Tylenol No. 3, Naprosyn, and an extremely proscriptive 10-pound lifting were endorsed. On May 15, 2014, the applicant was given a primary diagnosis of lumbar strain, lumbar radiculopathy, contusion of hip, degenerative disk disease and joint disease of the lumbar spine. Physical therapy and the same, unchanged 10-pound lifting limitation were endorsed. On November 6, 2014, the applicant

again reported persistent complaints of low back pain. Hyposensorium was noted about the lower extremities, right greater than left, in the L5-S1 distribution. Tylenol No. 3, Prilosec, and physical therapy were endorsed. It was stated that the applicant's spine specialist had endorsed further diagnostic studies, which are yet to be performed. A lumbar MRI of November 28, 2014 was notable for a 4-mm disk bulge at L4-L5 with associated moderate spinal stenosis and bilateral foraminal encroachment. On November 4, 2014, the applicant's spine/pain management specialist noted that the applicant had highly variable 6 to 9/10 low back complaints. The applicant had a significant extruded disk at L4-L5 causing thecal sac impingement and nerve root compression. The treating provider stated that the applicant had consulted a spine surgeon, who informed him that he is a candidate for an L4-L5 discectomy. The applicant's pain management physician likewise stated that the applicant's L4-L5 disk protrusion was of clinical significance. The applicant had a past medical history notable for depression, hypertension, gastritis, stomach ulcer, anxiety, and stroke. Epidural steroid injection therapy was sought.

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

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

**EMG (electromyography) left lower extremity:** Upheld

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

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

**Decision rationale:** As noted in the MTUS-adopted ACOEM Guidelines in Chapter 12, Table 12-8, page 309, EMG testing is considered "not recommended" for applicants with a clinically obvious radiculopathy, as appears to be the case here. The applicant has clinically evident, radiographically-confirmed lumbar radiculopathy. Both the applicant's pain management physician and spine surgeon have opined that a 4-mm disk bulge at L4-L5 generating associated spinal stenosis and neural foraminal encroachment is the source of the applicant's ongoing radicular complaints, effectively obviating the need for the proposed EMG. Therefore, the request is not medically necessary.

**EMG (electromyography) left lower extremity:** Upheld

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

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

**Decision rationale:** As noted in the MTUS-adopted ACOEM Guidelines in Chapter 12, Table 12-8, page 309, EMG testing is "not recommended" for applicants with a clinically obvious radiculopathy. Here, the applicant has a clinically evident, radiographically-confirmed lumbar radiculopathy at the L4-L5 level, both the applicant's spine surgeon and pain management

physician have opined, effectively obviating the need for the proposed EMG testing. Therefore, the request is not medically necessary.