

Case Number:	CM14-0216571		
Date Assigned:	01/06/2015	Date of Injury:	04/25/2013
Decision Date:	02/28/2015	UR Denial Date:	12/04/2014
Priority:	Standard	Application Received:	12/26/2014

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. 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 (IW) is a 26-year-old man with a date of injury of April 25, 2013. The mechanism of injury occurred when another order picker stuck his machine, resulting in a sharp jolt to his back. The injured worker's working diagnosis is herniated lumbar disc with radiculitis/radiculopathy left greater than right, status post epidural steroid injection (ESI) X 1 with no lasting relief from pain. An MRI of the lumbar spine dated January 30, 2014 showed L4-L5 disc desiccation; T12-L1, and L2 Schmorl's nodes; L3-L4 disc protrusion effacing the thecal sac; L4-L5 disc extrusion with stenosis of the left neural foramina that effaces the left exiting L4 nerve root; L5-S1 disc protrusion effacing the thecal sac; and small peri-neural cysts along the S1 transiting nerve roots bilaterally. Pursuant to the progress note dated November 7, 2014, the IW complains of low back pain with bilateral lower extremity radicular symptoms. Pertinent examination findings showed positive straight leg raise testing bilaterally, hypoesthesia along the bilateral L5 and S1 dermatomes, weakness on the big toe dorsiflexion and plantarflexion bilaterally, and 1+ deep tendon reflexes at the ankles. The result of EMG/NCV previously done was not provided for further consideration of this request. There was no objective evidence of progression or significant change in the injured worker's condition from the time the previous (undated) EMG/NCV to the bilateral lower extremities. It was the recommendation of the QME dated July 23, 2014 that the IW undergo "new" EMG/NCV studies. Treatment plan includes request 2nd ESI at L3-L4 and L4-L5, request repeat EMG/NCV of the lower extremities to further evaluate nerve injury, and request for acupuncture therapy 2 times a week for 3 weeks.

The current request is for electromyography and nerve conduction velocity studies 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:

1 Electromyography and Nerve Conduction Velocity Studies of the 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, Online Edition Chapter: Low Back Lumbar & Thoracic (Acute & Chronic), Nerve conduction studies (NCS)

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

Decision rationale: Pursuant to the Official Disability Guidelines, an EMG/NCV bilateral lower extremity is 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, EMGs are not necessary if radiculopathy is already clinically obvious. In this case, the injured worker's working diagnosis is herniated lumbar disc with radiculitis/radiculopathy left greater than right, status post epidural steroid injection (ESI) X 1 with no lasting relief from pain. An MRI of the lumbar spine dated January 30, 2014 showed L4-L5 disc desiccation; T12-L1, and L2 Schmorl's nodes; L3-L4 disc protrusion effacing the thecal sac; L4-L5 disc extrusion with stenosis of the left neural foramina that effaces the left exiting L4 nerve root; L5-S1 disc protrusion effacing the thecal sac; and small peri-neural cysts along the S1 transiting nerve roots bilaterally. The result of prior EMG/NCV was not provided for further consideration of this request. There was no objective evidence of progression or significant change in the injured worker's condition from the previous (undated) EMG/NCV to the bilateral lower extremities. It was the recommendation of the QME dated July 23, 2014 that the IW undergo "new" EMG/NCV studies. The guidelines state there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Radiculopathy was established on prior EMG/NCV studies. There is no clinical justification to repeat the EMG/NCV of the bilateral lower extremities. Consequently, absent clinical documentation to support repeating EMGs/NCVs of the lower extremities bilaterally, an EMG/NCV bilateral lower extremity is not medically necessary.