

Case Number:	CM15-0113486		
Date Assigned:	06/19/2015	Date of Injury:	08/26/2014
Decision Date:	08/24/2015	UR Denial Date:	05/29/2015
Priority:	Standard	Application Received:	06/12/2015

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
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 47 year old male who sustained an industrial injury on 08/26/2014. Current diagnoses include degenerative disc disease-lumbar, extensive facial fractures, rib fractures, and nausea. Previous treatments included medication management and aquatic therapy. Previous diagnostic studies include a cervical spine MRI dated 11/13/2014, cervical spine x-ray dated 03/09/2015, and CT scan of the cervical spine dated 02/20/2015, and right upper extremity EMG dated 02/20/2015. Initial injuries included multiple rib fractures, liver laceration, and facial fractures. Report dated 05/04/2015 noted that the injured worker presented with complaints that included headaches, fatigue, loss of consciousness, memory loss, low back pain with right leg pain and bowel incontinence, severe neck pain with numbness, tingling to the right arm/hand with flares every day, vision problems, ringing in ears, abdominal pain, and mid back pain. Pain level was not included. Physical examination was positive for increased symptoms in the right leg, increased problems with bladder and bowel control, tinnitus in both ears, and moderate pain in the right ribs. The treatment plan included refilling Motrin, Lidoderm patches, and Zofran, request for x-rays, and follow up in 4 weeks. Disputed treatments include EMG Right lower extremity, EMG Left lower extremity, NCV Right lower extremity, and NCV Left lower extremity.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG Right lower extremity: Overturned

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): 303.

Decision rationale: The patient was injured on 08/26/14 and presents with headaches, fatigue, loss of consciousness, memory loss, low back pain with right leg pain and bowel incontinence, severe neck pain with numbness, tingling to the right arm/hand with flares every day, vision problems, ringing in ears, abdominal pain, and mid back pain. The request is for an EMG OF THE RIGHT LOWER EXTREMITY. The utilization review denial rationale is that there is no documentation as to why an EMG nerve conduction study is need for Radiculopathy when the patient has already received an MRI of the lumbar spine. There is no RFA provided and the patient is totally incapacitated. The 11/13/14 MRI of the thoracic spine revealed DDD, disc protrusion at T7-T8 with canal stenosis, disc protrusions at T9-T10 with narrowing of left neural foramin. The 11/13/14 MRI of the lumbar spine revealed facet arthropathy, disc bulg, osteophyita at L5-S1 with severe bilateral neuroforaminal stenosis, facet arthropathy and disc bulg at L4-L5 with mod-severe neuroforaminal stenosis and narrowing, disc bulg and facet arthoropathy at L3-L4 with mod neuroforaminal stenosis and displacement of both L4 nerve roots. There is no prior EMG/NCV studies of the lower extremity provided. For EMG, ACOEM Guidelines page 303 states, Electromyography including H-reflex test may be useful to identify subtle, focal neurologic dysfunction, patient with low back pain lasting more than 3 or 4 weeks. The reason for the request is not provided. On 05/04/15, the patient stated that the lower back is getting progressively worse, getting worse into the right leg pain soreness in the thoracic area. He is diagnosed with lumbar DDD, thoracic HNP, nausea, and cervical spine pain. Given that the patient has not had a prior EMG of the right lower extremity and continues to have low back pain going into the right leg, the requested EMG of the right lower extremity appears medically reasonable. The request IS medically necessary.

EMG 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): 303.

Decision rationale: The patient was injured on 08/26/14 and presents with headaches, fatigue, loss of consciousness, memory loss, low back pain with right leg pain and bowel incontinence, severe neck pain with numbness, tingling to the right arm/hand with flares every day, vision problems, ringing in ears, abdominal pain, and mid back pain. The request is for an EMG OF THE LEFT LOWER EXTREMITY. The utilization review denial rationale is that there is no documentation as to why an EMG nerve conduction study is need for Radiculopathy when the patient has already received an MRI of the lumbar spine. There is no

RFA provided and the patient is totally incapacitated. The 11/13/14 MRI of the thoracic spine revealed DDD, disc protrusion at T7-T8 with canal stenosis, disc protrusions at T9-T10 with narrowing of left neural foramin. The 11/13/14 MRI of the lumbar spine revealed facet arthropathy, disc bulg, osteophyita at L5-S1 with severe bilateral neuroforaminal stenosis, facet arthropathy and disc bulg at L4-L5 with mod-severe neuroforaminal stenosis and narrowing, disc bulg and facet arthropathy at L3-L4 with mod neuroforaminal stenosis and displacement of both L4 nerve roots. There are no prior EMG/NCV studies of the lower extremity provided. For EMG, ACOEM Guidelines page 303 states, Electromyography including H-reflex test may be useful to identify subtle, focal neurologic dysfunction, patient with low back pain lasting more than 3 or 4 weeks. The reason for the request is not provided. On 05/04/15, the patient stated that the lower back is getting progressively worse, getting worse into the right leg pain soreness in the thoracic area. He is diagnosed with lumbar DDD, thoracic HNP, nausea, and cervical spine pain. Given that the patient has low back pain going to the right leg and not the left leg, an EMG of the left lower extremity does not appear to be medically reasonable. The request IS NOT medically necessary.

NCV Right lower extremity: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back - Nerve conduction studies (NCS).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Lumbar & Thoracic (Acute & Chronic) chapter, Nerve conduction studies (NCS).

Decision rationale: The patient was injured on 08/26/14 and presents with headaches, fatigue, loss of consciousness, memory loss, low back pain with right leg pain and bowel incontinence, severe neck pain with numbness, tingling to the right arm/hand with flares every day, vision problems, ringing in ears, abdominal pain, and mid back pain. The request is for a NCV RIGHT LOWER EXTREMITY. The utilization review denial rationale is that there is no documentation as to why an EMG nerve conduction study is need for Radiculopathy when the patient has already received an MRI of the lumbar spine. There is no RFA provided and the patient is totally incapacitated. The 11/13/14 MRI of the thoracic spine revealed DDD, disc protrusion at T7-T8 with canal stenosis, disc protrusions at T9-T10 with narrowing of left neural foramin. The 11/13/14 MRI of the lumbar spine revealed facet arthropathy, disc bulg, osteophyita at L5-S1 with severe bilateral neuroforaminal stenosis, facet arthropathy and disc bulg at L4-L5 with mod-severe neuroforaminal stenosis and narrowing, disc bulg and facet arthropathy at L3-L4 with mod neuroforaminal stenosis and displacement of both L4 nerve roots. There are no prior EMG/NCV studies of the lower extremity provided. MTUS and ACOEM Guidelines do not discuss NCV. However, ODG Guidelines have the following regarding NCV studies, not recommended. There is no justification performing nerve conduction studies when the patient has presumed symptoms on the basis of Radiculopathy. The systematic review and meta-analysis demonstrate that neurologic testing procedures do have limited overall diagnostic accuracy in detecting disk herniation with suspected radiculopathy. The reason for the request is

not provided. On 05/04/15, the patient stated that the lower back is getting progressively worse, getting worse into the right leg pain soreness in the thoracic area. He is diagnosed with lumbar DDD, thoracic HNP, nausea, and cervical spine pain. In this situation, NCV studies are not recommended per ODG guidelines if the leg symptoms are presumed to be coming from the spine. Therefore, the requested NCV of the right lower extremity IS NOT medically necessary

NCV Left lower extremity: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back - Nerve conduction studies (NCS).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Lumbar & Thoracic (Acute & Chronic) chapter, Nerve conduction studies (NCS).

Decision rationale: The patient was injured on 08/26/14 and presents with headaches, fatigue, loss of consciousness, memory loss, low back pain with right leg pain and bowel incontinence, severe neck pain with numbness, tingling to the right arm/hand with flares every day, vision problems, ringing in ears, abdominal pain, and mid back pain. The request is for a NCV LEFT LOWER EXTREMITY. The utilization review denial rationale is that there is no documentation as to why an EMG nerve conduction study is need for Radiculopathy when the patient has already received an MRI of the lumbar spine. There is no RFA provided and the patient is totally incapacitated. The 11/13/14 MRI of the thoracic spine revealed DDD, disc protrusion at T7-T8 with canal stenosis, disc protrusions at T9-T10 with narrowing of left neural foramin. The 11/13/14 MRI of the lumbar spine revealed facet arthropathy, disc bulg, osteophyita at L5-S1 with severe bilateral neuroforaminal stenosis, facet arthropathy and disc bulg at L4-L5 with mod-severe neuroforaminal stenosis and narrowing, disc bulg and facet arthropathy at L3-L4 with mod neuroforaminal stenosis and displacement of both L4 nerve roots. There are no prior EMG/NCV studies of the lower extremity provided. MTUS and ACOEM Guidelines do not discuss NCV. However, ODG Guidelines have the following regarding NCV studies, not recommended. There is no justification performing nerve conduction studies when the patient has presumed symptoms on the basis of Radiculopathy. The systematic review and meta-analysis demonstrate that neurologic testing procedures do have limited overall diagnostic accuracy in detecting disk herniation with suspected Radiculopathy. The reason for the request is not provided. On 05/04/15, the patient stated that the lower back is getting progressively worse, getting worse into the right leg pain soreness in the thoracic area. He is diagnosed with lumbar DDD, thoracic HNP, nausea, and cervical spine pain. In this situation, NCV studies are not recommended per ODG guidelines if the leg symptoms are presumed to be coming from the spine. Therefore, the requested NCV of the left lower extremity IS NOT medically necessary.