

Case Number:	CM15-0122898		
Date Assigned:	07/07/2015	Date of Injury:	07/14/2014
Decision Date:	08/07/2015	UR Denial Date:	06/03/2015
Priority:	Standard	Application Received:	06/25/2015

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, Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management, Hospice & Palliative 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 is a 45 year old male who sustained an industrial injury on 07/14/2014 as a [REDACTED] driver. The injured worker was diagnosed with disc protrusion with foraminal stenosis, multi-level discogenic changes with degenerative disc disease and radiculopathy/radiculitis. Treatment to date has included diagnostic testing with recent lumbar magnetic resonance imaging (MRI) on February 10, 2015, physical therapy, acupuncture therapy, back brace and medications. According to the primary treating physician's progress report on May 22, 2015, the injured worker continues to experience back pain radiating into his legs, predominantly on the right side. The injured worker also reports neck, mid back and upper extremity pain with numbness. The injured worker rates his pain level at 2-4/10. Examination of the lumbar spine demonstrated a normal gait with pain to palpation over L4-5 and L5-S1 with spasms. There was limited range of motion due to pain documented at 50% normal flexion, 40% normal extension and 60% normal bilateral side to side bending. Motor strength noted 5-/5 of the right extensor hallucis longus muscle and gastrocnemius, otherwise 5/5 proximally and distally. Deep tendon reflexes were 1+ at the ankle and knee with sensory intact in the bilateral lower extremities. Straight leg raise was positive on the right at 90 degrees with pain radiating into the leg. Negative straight leg raise was noted on the left side. Current medications are listed as Norco, Tramadol, Meloxicam, Celecoxib and Tizanidine. Treatment plan consists of considering epidural steroid injection, facet medial branch block and neurotomies, physical therapy for the upper back and neck area, lumbar flexion/extension X-rays, thoracic and cervical magnetic

resonance imaging (MRI) and the current request for Electromyography (EMG)/Nerve Conduction Velocity (NCV) 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:

EMG/NCV of bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, NCS.

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 EMG/NCV of the lower extremities, Occupational Medicine 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. They go on to state that electromyography may be useful to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than 3 to 4 weeks. ODG states that nerve conduction studies are not recommended for back conditions. They go on to state that there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Within the documentation available for review, there are physical examination findings supporting a diagnosis of specific nerve compromise. Additionally, imaging studies already show specific nerve compromise. Therefore, the currently requested EMG/NCV of the lower extremities is not medically necessary.