

Case Number:	CM15-0171671		
Date Assigned:	09/14/2015	Date of Injury:	08/04/2014
Decision Date:	10/13/2015	UR Denial Date:	08/21/2015
Priority:	Standard	Application Received:	08/31/2015

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: North Carolina
 Certification(s)/Specialty: Family Practice

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 51 year old male who sustained an injury on 8-4-14 resulting when he fell down approximately 5-6 feet, face first. He sustained abrasions and contusion on his left leg; hit his back and right palmar hand. The Agreed Medical Examination from 8-5-15 indicates X-rays of the left leg were negative. He was prescribed Ibuprofen and work restrictions. Treatment included physical therapy for his back pain but that did not relieve his symptoms. MRI (2-26-15) lumbar spine; EMG, nerve conduction study of the bilateral lower extremities (4-16-15) revealed there is electrodiagnostic evidence of right chronic L5 radiculopathy; no evidence of lumbar radiculopathy, peripheral neuropathy or mononeuropathy involving the bilateral tibial and peroneal nerves. Diagnoses are contusions, bilateral hands, resolved; herniated nucleus pulposus of the lumbar spine with radiculopathy; contusions, left thigh and calf. The physical examination of his knees revealed active range of motion in right and left knee flexion are normal; straight leg raise on the right is positive at 50 degrees and left was negative at 70 degrees. His activities of daily living indicate his self-care activities are uncomfortable; can only lift, push and pull light to medium objects; can only sit 30-60 minutes at a time; and he has a lot of difficulty bending, kneeling and squatting. 8-14-15 the examination indicates he has low back and leg pain. The physical examination reveals there is tenderness to palpation to the lumbar paraspinals; range of motion is 70% of normal; lower extremity normal; range of motion-straight leg raise is negative; reflexes right patellar and left are normal; sensory hypoesthesia left anterior thigh. He reports right L5 nerve root block helped marginally but did not provide significant long term pain relief. The plan was to refer him for acupuncture treatments x 6 session and EMG, NC study of the left

leg to evaluate for radiculopathy. He is temporarily totally disabled. Current requested treatments repeat EMG, NCS of the left leg to check for radiculopathy. Utilization review 8-21-15 requested treatments are not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Repeat EMG/NCS of the left leg to check for radiculopathy: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Lumbar & Thoracic (Acute & Chronic) Chapters: EMGs (electromyography) and Nerve Conduction Studies (NCS).

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

Decision rationale: The ACOEM chapters on low back complaints and the need for lower extremity EMG/NCV states: Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures). Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. There are unequivocal objective findings of nerve compromise on the neurologic exam provided for review. However, there is not mention of surgical consideration. There are no unclear neurologic findings on exam. For these reasons, criteria for lower extremity EMG/NCV have not been met as set forth in the ACOEM. Therefore, the request is not medically necessary.