

<b>Case Number:</b>	CM15-0178551		
<b>Date Assigned:</b>	09/18/2015	<b>Date of Injury:</b>	09/30/2000
<b>Decision Date:</b>	11/18/2015	<b>UR Denial Date:</b>	09/01/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/10/2015

### 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, Arizona

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 75 year old male, who sustained an industrial injury on 9-30-2000. The injured worker was diagnosed as having pain in joint shoulder region; cervicgia; long-term use of other medications; encounter for therapeutic drug monitoring; depressive disorder not elsewhere classified; other pain disorders related to psychological factors; displacement of lumbar intervertebral disc without myelopathy. Treatment to date has included physical therapy; medications. Diagnostics studies included MRI lumbar spine (6-4-15); EMG-NCV lower extremities (8-31-15). Currently, the PR-2 notes dated 8-12-15 indicated the injured worker was in the office as a follow-up visit. The injured worker presents on this day for a follow-up of chronic low back and left shoulder pain. The injured worker reports he continues to have significant low back pain with radiation into the lower extremities, right greater than the left. He reports he has a strong cold sensation in the right lateral and posterior calf. He reports he feels that from the waist down, both legs are very heavy. He also reports he is no longer driving because of the leg pain and his wife has to drive him. The provider documents "he states he did not get the Nortriptyline and so he used left over gabapentin at 3 tablets a day. This does help to reduce his lower extremity pain and feels more comfortable with sitting. He feels it actually does work better than the Topamax. He reports having reduction from 8-9 out of 10 on VAS down to 6 out of 10 with this. He denies side effects with this. He reports having episodes of urinary incontinence over the past month. He also has burning sensation and he called the PCP. They took a urine sample and he was diagnosed with urinary tract infection. He took antibiotics last week and the burning went away. However, the incontinence is still present. Upon further

questioning the patient is describing urinary urgency and not true incontinence. He states that he is aware he had to urinate but cannot get to the bathroom on time and he has difficulty holding his urine." The injured worker reports he saw a surgeon on consultation on 7-17-15. He states the surgeon reviewed his MRIs and showed him that his spine is getting progressively worse. He recommended updating his EMG studies to compare to the prior 2014. He states the surgeon did feel surgery may be needed, however wants the updated test. The injured worker's medical history includes diabetes, hypertension, lumbar disc disease and previous surgeries of right knee, shoulder surgery and cervical myelopathy (1-10-04). The provider documents his physical examination noting lumbar extension was measured to be 5 degrees, flexion 40 degrees, left lateral bending 10 degrees, right 15 degrees, sensation is decreased in the dermatomes left, right L5, left and right S1. Straight leg raise is positive bilaterally, spasm and guarding is noted and motor strength is 5 out of 5 to hip flexion, hip extension, knee extension, knee flexion, ankle eversion, ankle inversion and extensor hallicis longus. The provider documents all of the present and past diagnostics. The most recent: MRI of the lumbar spine without contrast was done on 6-4-15 with an impression documented as: "1) Overall interval exacerbation since 2010 specifically at L3-L4, L4- L5 and L5-S1. 2) At L5-S1, broad based disc bulge is seen. The central herniated disc measures 18mm in transverse, 5mm in AP dimension. There is moderate to severe bilateral foraminal stenosis. Canal is patent. Hypertrophic facet disease contributes. 3) At L4-L5, broad based herniated disc is seen across the disc space with superimposed bulge. There is severe bilateral foraminal stenosis. There is mild central canal stenosis. Hypertrophic facet disease, ligamentum flavum hypertrophy and spondylolisthesis contribute. 4) At L3-L4, a broad based disc herniation is present across the disc space, measure 7mm in AP dimension. There is severe bilateral foraminal stenosis and moderate central canal stenosis. Hypertrophic facet disease and ligamentum flavum hypertrophy contribute. 5) At L2-L3, disc bulge is seen. Both foramina are mildly narrowed. Canal is patent. 6) At L1-L2, broad based disc bulge is seen. The central herniated disc measured 5mm in AP dimension. There is mild to moderate canal stenosis. Both foramina are mildly narrowed. 7) At T12-L1, superimposed bulge with superimposed right paracentral disc protrusion. There is moderate right and mild left foraminal stenosis." An EMG- NCV study of the lower extremities dated 8-31-15 impression is documented as 1) Abnormal but limited study 2) Electrodiagnostic evidence of bilateral L5-S1 radiculopathy, with ongoing denervation, consistent with the results of the prior electrodiagnostic examination. A Request for Authorization is dated 9-10-15. A Utilization Review letter is dated 9-1-15 and non-certification was for a bilateral lower extremity EMG-NCV. Utilization Review denied the requested treatment for not meeting the CA MTUS, ACOEM and ODG Guidelines. The provider is requesting authorization of bilateral lower extremity EMG-NCV (date of service 8-31-15).

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

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

**EMG left lower extremity: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Lumbar & Thoracic (Acute & Chronic).

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, NCS/EMG.

**Decision rationale:** According to the California MTUS, Nerve Conduction and EMG studies can be considered to help identify subtle neurologic dysfunction. These studies can be indicated to identify causes of pain that include radiculopathy, and compression or entrapment neuropathies. They are warranted after failure of conservative management for 4-6 weeks. According to ODG Guidelines, EMG/NCS topic, it is stated that this testing is recommended depending on indications and EMG and NCS are separate studies and should not necessarily be done together. ODG further states, "NCS is not recommended, but EMG is recommended as an option (needle to surface) to obtain unequivocal evidence of radiculopathy, after 1-month of conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious." Records were reviewed describing the Providers rationale for wanting an updated electrodiagnostic study of the bilateral lower extremities, including formulating a definitive treatment plan. However, it should be noted that there was a recent (June of 2015) MRI of the lumbar spine corroborating the physical exam findings of radiculopathy, and it is not clear why a repeat NCS/EMG would formulate a treatment plan. There was clinically obvious radiculopathy in the setting of worsening back pain, but no red flags to warrant urgent surgery (saddle anesthesia, bowel/bladder changes other than urge incontinence). This request does not fully meet the above criteria, and unfortunately, cannot be supported in this clinical setting and 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, Lumbar & Thoracic (Acute & Chronic), Nerve Conduction studies (NCS).

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, NCS/EMG.

**Decision rationale:** According to the California MTUS, Nerve Conduction and EMG studies can be considered to help identify subtle neurologic dysfunction. These studies can be indicated to identify causes of pain that include radiculopathy, and compression or entrapment neuropathies. They are warranted after failure of conservative management for 4-6 weeks. According to ODG Guidelines, EMG/NCS topic, it is stated that this testing is recommended depending on indications and EMG and NCS are separate studies and should not necessarily be done together. ODG further states, "NCS is not recommended, but EMG is recommended as an option (needle to surface) to obtain unequivocal evidence of radiculopathy, after 1-month of conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious." Records were reviewed describing the Providers rationale for wanting an updated electrodiagnostic study of the bilateral lower extremities, including formulating a definitive treatment plan. However, it should be noted that there was a recent (June of 2015) MRI of the lumbar spine corroborating the physical exam findings of radiculopathy, and it is not clear why a repeat NCS/EMG would formulate a treatment plan. There was clinically obvious

radiculopathy in the setting of worsening back pain, but no red flags to warrant urgent surgery (saddle anesthesia, bowel/bladder changes other than urge incontinence). This request does not fully meet the above criteria, and unfortunately, cannot be supported in this clinical setting and 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, Lumbar & Thoracic (Acute & Chronic), Nerve Conduction studies (NCS).

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, NCS/EMG.

**Decision rationale:** According to the California MTUS, Nerve Conduction and EMG studies can be considered to help identify subtle neurologic dysfunction. These studies can be indicated to identify causes of pain that include radiculopathy, and compression or entrapment neuropathies. They are warranted after failure of conservative management for 4-6 weeks. According to ODG Guidelines, EMG/NCS topic, it is stated that this testing is recommended depending on indications and EMG and NCS are separate studies and should not necessarily be done together. ODG further states, "NCS is not recommended, but EMG is recommended as an option (needle to surface) to obtain unequivocal evidence of radiculopathy, after 1-month of conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious." Records were reviewed describing the Providers rationale for wanting an updated electrodiagnostic study of the bilateral lower extremities, including formulating a definitive treatment plan. However, it should be noted that there was a recent (June of 2015) MRI of the lumbar spine corroborating the physical exam findings of radiculopathy, and it is not clear why a repeat NCS/EMG would formulate a treatment plan. There was clinically obvious radiculopathy in the setting of worsening back pain, but no red flags to warrant urgent surgery (saddle anesthesia, bowel/bladder changes other than urge incontinence). This request does not fully meet the above criteria, and unfortunately, cannot be supported in this clinical setting and is not medically necessary.

**EMG right lower extremity:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Lumbar & Thoracic (Acute & Chronic), Nerve conduction studies.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, NCS/EMG.

**Decision rationale:** help identify subtle neurologic dysfunction. These studies can be indicated to identify causes of pain that include radiculopathy, and compression or entrapment neuropathies. They are warranted after failure of conservative management for 4-6 weeks. According to ODG Guidelines, EMG/NCS topic, it is stated that this testing is recommended depending on indications and EMG and NCS are separate studies and should not necessarily be done together. ODG further states, "NCS is not recommended, but EMG is recommended as an option (needle to surface) to obtain unequivocal evidence of radiculopathy, after 1-month of conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious." Records were reviewed describing the Providers rationale for wanting an updated electrodiagnostic study of the bilateral lower extremities, including formulating a definitive treatment plan. However, it should be noted that there was a recent (June of 2015) MRI of the lumbar spine corroborating the physical exam findings of radiculopathy, and it is not clear why a repeat NCS/EMG would formulate a treatment plan. There was clinically obvious radiculopathy in the setting of worsening back pain, but no red flags to warrant urgent surgery (saddle anesthesia, bowel/bladder changes other than urge incontinence). This request does not fully meet the above criteria, and unfortunately, cannot be supported in this clinical setting.