

Case Number:	CM15-0179803		
Date Assigned:	09/21/2015	Date of Injury:	12/01/2008
Decision Date:	10/27/2015	UR Denial Date:	09/08/2015
Priority:	Standard	Application Received:	09/14/2015

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:

This is a 31 year old male with a date of injury on 12-1-2008. A review of the medical records indicates that the injured worker is undergoing treatment for lumbar spine degenerative disc disease with facet arthropathy and lumbar radiculopathy. According to the progress report dated 8-4-2015, the injured worker complained of increased numbness in both his lower extremities. He said that at times both his legs go completely numb. He complained of back pain rated three to six out of ten. The back pain radiated down the left leg to the ankle. He reported that his activity level was limited by pain. He reported that Flexeril helped with his spasms. Per the treating physician (8-4-2015), the injured worker was working with modified duty. The physical exam (8-4-2015) revealed a mildly antalgic gait. Range of motion of the lumbar spine was decreased in all planes and limited by pain. There was decreased sensation in the L4, L5 and S1 dermatomes on the left. Treatment has included Microlumbar Discectomy (MLD), physical therapy, chiropractic treatment, acupuncture, a home exercise program, and medications. It was noted that the injured worker had not had electromyography (EMG)-nerve conduction study (NCS) of the lower extremities since before surgery in 2012. The request for authorization dated 8-4-2015 was for updated electromyography (EMG) of the bilateral lower extremities. The original Utilization Review (UR) (9-8-2015) denied a request for repeat electromyography (EMG) 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:

Repeat EMG of bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back.

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.