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| Case Number: | CM15-0022277 | | |
| Date Assigned: | 02/11/2015 | Date of Injury: | 03/31/2009 |
| Decision Date: | 04/09/2015 | UR Denial Date: | 01/12/2015 |
| Priority: | Standard | Application Received: | 02/05/2015 |

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, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 50-year-old female, who sustained an industrial injury on 03/31/2009. She has reported low back pain, neck pain, and right shoulder pain. The diagnoses have included cervical disc degeneration; sprain right rotator cuff; lumbar radiculitis; lumbar degenerative disc disease; and chronic pain syndrome. Treatment to date has included medications, lumbar epidural injections, acupuncture, chiropractic sessions, and physical therapy. Medications have included Neurontin, Naproxen, Norco, and Nucynta ER. Currently, the IW complains of aching pain in the right shoulder, the neck, and the low back, which can radiate down the back of the legs with numbness and tingling, worse on the right. A progress note from the treating physician, dated 12/29/2014, reports objective findings to include tenderness in the paracervical muscles; moderately tenderness in the paraspinal muscles of the lumbar spine; sensation is decreased in the right posterior leg; straight leg raising is positive bilaterally; and decreased range of motion of the right shoulder. The treatment plan has included request for EMG/NCS of the bilateral lower extremities to assess for nerve root distribution. On 01/12/2015 Utilization Review non-certified a prescription for EMG/NCS of the Bilateral Lower Extremities. The MTUS, ACOEM Guidelines was cited. On 02/05/2015, the injured worker submitted an application for IMR for review of EMG/NCS 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/NCS of the Bilateral Lower Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 60-61.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177.

Decision rationale: ACOEM guidelines support ordering of imaging studies for emergence of red flags, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. Per MTUS ACOEM p182, with regard to the detection of neurologic abnormalities, EMG for diagnosis of nerve root involvement if findings of history, physical exam, and imaging study are consistent, is not recommended. Per the documentation submitted for review, the injured worker had an EMG dated 8/3/11, which was negative for lumbar radiculopathy. MRI dated 11/20/12 revealed L4-L5 degenerative changes with posterior element hypertrophy and Grade I anterolisthesis as well as a broad based posterior disc bulge or protrusion. The central canal was mildly narrowed. Lateral recesses were narrowed. There was facet arthropathy at L5-S1. While it is noted that the injured worker has decreased sensation on the right posterior leg, and positive straight leg raise bilaterally, repeat EMG/NCS is not supported without significant neurologic change. The request is not medically necessary.