Case Number:	CM15-0094350		
Date Assigned:	05/21/2015	Date of Injury:	11/30/2009
Decision Date:	06/25/2015	UR Denial Date:	05/06/2015
Priority:	Standard	Application Received:	05/18/2015

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: Texas, California
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 57 year old male, who sustained an industrial injury on 11/30/2009, due to continuous trauma, while employed as a mechanic service technician. The injured worker was diagnosed as having status post lumbar surgery with worsening symptoms, rule out cauda equina syndrome, tremors of the lower extremities to be further determined, cervical sprain/strain with cervical disc disease, psychological factors affecting physical condition, with complaints of depression and suicidal thoughts, and chronic pain medication. Treatment to date has included diagnostics, chiropractic, physical therapy, aqua therapy, interferential unit, lumbar surgery in 3/2012, psychological therapy, and medications. A Qualified Medical Examination in Urology (10/29/2014) noted a complaint of urinary frequency and post void dribbling, with slow stream, for 2 years. Currently, on 4/15/15 the injured worker complains of persistent low back pain (rated 6-8/10), with radiation into the right lower extremity, intermittently radiating to the left lower extremity, with associated numbness, tingling, weakness, and shakiness. He also reported intermittent neck and back pain, headaches, and clonus like shaking involving the lower extremity. It was documented that on or about 8/16/2014, he felt dizziness while walking and was weak in his left side, subsequently falling onto his left side and hitting head. He continued to complain of left knee weakness. Current medications included Prilosec, Glucosamine, Flexeril, Norco, Celebrex, and Ultracin topical cream. Urine toxicology (4/15/2015) was documented as consistent with prescribed medications. His work status was total temporary disability. Exam noted a walker for ambulation, with right side limping. Exam of the back noted midline tenderness from L2-S1, right lumbar facet tenderness L4-S1 and painful thoracic and lumbar spine movements. Sensory exam showed altered distribution in the right L5-S1 nerve root. He was unable perform heel and toe walk and had normal reflexes. Motor exam noted

some weakness in both legs, right greater than left. Electromyogram and nerve conduction studies of the lower extremities (4/2011) suggested left peroneal sensory neuropathy. Study was limited due to poor effort. Electromyogram and nerve conduction studies of the lower extremities (2/2013) suggested chronic denervation potential in bilateral L5 and S1 myotome, indicating chronic bilateral L5-S1 radiculopathy. It was documented that neurologist consultation (12/16/2014) recommended electromyogram and nerve conduction studies of the lower extremities, somatosensory evoke potentials of upper extremities and lower extremities, related to ataxia, and electroencephalogram related to body tremors of lower extremities. The rationale was noted to determine if there was ongoing physical basis for his complaints and treatments thereof. Magnetic resonance imaging of the lumbar spine reports were referenced but not submitted. The medication list include Flexeril, Norco, Glucosamine, Celebrex and Prilosec. The patient had received ESI for this injury. The patient has had MRI of the low back on 5/7/14 that revealed disc bulge with foraminal narrowing, degenerative changes. The patient has had X-ray of low back that was normal. The patient has used walker.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG of the bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304.

Decision rationale: EMG of the bilateral lower extremities. Per ACOEM chapter 12 guidelines, "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." Per the ACOEM guidelines cited below, "For most patients presenting with true neck or upper back problems, special studies are not needed unless a three- or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out. 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." Electromyogram and nerve conduction studies of the lower extremities (4/2011) suggested left peroneal sensory neuropathy. Study was limited due to poor effort. Electromyogram and nerve conduction studies of the lower extremities (2/2013) suggested chronic denervation potential in bilateral L5 and S1 myotome, indicating chronic bilateral L5-S1 radiculopathy. Any significant changes in objective physical examination findings since the last electro diagnostic study that would require a repeat electrodiagnostic study were not specified in the records provided.The details of PT or other types of therapy done since the date of injury were not specified in the records provided. The records submitted contain no accompanying current PT evaluation for this patient. A detailed response to a complete course of conservative therapy including PT visits was not specified in the records provided. Previous PT visit notes were not specified in the records provided. The response of the symptoms to a period of rest and oral pharmacotherapy was not specified in the records provided. The request for EMG of the bilateral lower extremities is not medically necessary for this patient.

NCV of the bilateral lower extremities: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304.

Decision rationale: NCV of the bilateral lower extremities. Per ACOEM chapter 12 guidelines, "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." Per the ACOEM guidelines cited below, "For most patients presenting with true neck or upper back problems, special studies are not needed unless a three- or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out. 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 ACOEM chapter 12 guidelines, "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." Per the ACOEM guidelines cited below, "For most patients presenting with true neck or upper back problems, special studies are not needed unless a three- or four-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided any red-flag conditions are ruled out. 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." Electromyogram and nerve conduction studies of the lower extremities (4/2011) suggested left peroneal sensory neuropathy. Study was limited due to poor effort. Electromyogram and nerve conduction studies of the lower extremities (2/2013) suggested chronic denervation potential in bilateral L5 and S1 myotome, indicating chronic bilateral L5-S1 radiculopathy. Any significant changes in objective physical examination findings since the last electro diagnostic study that would require a repeat electrodiagnostic study were not specified in the records provided. The details of PT or other types of therapy done since the date of injury were not specified in the records provided. The records submitted contain no accompanying current PT evaluation for this patient. A detailed response to a complete course of conservative therapy including PT visits was not specified in the records provided. Previous PT visit notes were not specified in the records provided. The request for NCV of the bilateral lower extremities is not medically necessary for this patient.