

Case Number:	CM14-0130112		
Date Assigned:	08/20/2014	Date of Injury:	06/30/2000
Decision Date:	11/17/2014	UR Denial Date:	07/31/2014
Priority:	Standard	Application Received:	08/14/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 59 year-old-female who sustained work-related injuries on June 30, 2000. On March 6, 2014, the injured worker reported continued daily neck pain, stiffness, muscle spasms and daily pain. She reported that her pain remained the same since last exam. Her pain level was rated as 8-9/10 and described it as moderate-to-severe, frequent, constant, dull, sharp, weakness and cramping. She reported severe frequent muscle spasms that limited her range of motion. However, her pain was reduced with medications to 5/10. She has completed four out of six acupuncture sessions. A cervical spine examination noted limited range of motion. Crepitus was noted with muscle spasms. Spasms were also noted in the cervicothoracic paraspinal muscles. A sheer depression test was positive. Active trigger points were in the bilateral lumbar spine scapulae and trapezius muscles. Right thumb active range of motion was slightly decreased in all ranges. Pain was noted in the A-1 module with triggering with active range of motion. On March 13, 2014, the injured worker returned to provider due to an acute flare-up of pain and spasms on her bilateral upper trapezius muscles, peri-scapularis, and (illegible) with upper extremity radiculopathy. She also reported of bowel or bladder symptoms. Her headaches have increased in frequency and severity with myofascial pain syndrome flare-up. The injured worker was initially seen for pool therapy on June 11, 2014. She has received pool therapy in the past. Due to recent exacerbation of pain she was instructed by her therapist to restart a short bout of skilled supervised pool therapy. She reported that she was seeking long term aquatic exercise program to address her long-term condition. Objectively, her lumbar spine range of motion was limited in all planes. Strength of the bilateral hip was 4-/5 and bilateral knee extension was 4+/5. Tripod test was positive. Most recent records dated July 15, 2014 documents that the injured worker has not received any documents regarding scheduling for an updated nerve conduction studies and electromyography (EMG). She complained of triggering in both

thumbs. She rated her pain 6/10 with medications but without medications her pain was rated 8/10. She reported experiencing increase in low back pain with radiation into the bilateral lower extremities with components of burning pain in the bilateral thighs with sharp/pinching pain. On examination, lumbar spine active range of motion was decreased in all planes. Tenderness was noted in the bilateral paravertebral musculature and bilateral sacroiliac joints as well as L5-S1 area. Kemp's test was positive bilaterally. A magnetic resonance imaging (MRI) of the lumbar spine revealed degenerative disc disease, disc bulge at L2-3 and L4-5, and facet stenosis. She is diagnosed with (a) cervical spine sprain and strain with increased myofascial pain syndrome (MFPS), (b) status post right trigger thumb basal joint arthroplasty and excision of trapezium with wire fixation/De Quervain's release on August 1, 2011, (c) history of right carpal tunnel release and right De Quervain's release on August 23, 2001, (d) lumbar spine sprain and strain with degenerative disc disease, 2-millimeter disc bulge at L3-L4; 4-millimeter disc bulge, facet osteoarthritis at L4-5 with central stenosis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Emg Bilateral Lower Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines- treatment for Workers Compensation, Online Edition Chapter, Low Back- Lumbar & Thoracic (Acute & Chronic)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Electrodiagnostic studies (EDS) Official Disability Guidelines (ODG) Low Back, EMGs (electromyography) Official Disability Guidelines (ODG) Low Back, Nerve Conduction Studies (NCS)

Decision rationale: According to evidence-based guidelines, electromyography (EMG) is considered to be an option to obtain unequivocal evidence of radiculopathy after one-month of conservative treatment. In this case, the injured worker as per July 15, 2014 records physical examination findings document of lumbar pain with radiation of burning pain going to down to her bilateral thighs with sharp/pinching pain. Lumbar spine range of motion was limited in all planes with noted tenderness in the bilateral lumbar paravertebral musculature and bilateral sacroiliac joint as well as over the L5-S1 area. A magnetic resonance imaging (MRI) scan of the lumbar spine (unknown date) revealed degenerative disc disease, 2-millimeter disc bulge at L3-L4; 4-millimeter disc bulge, facet osteoarthritis at L4-5 with central stenosis. However, provocative tests were absent (e.g. Straight leg raising test) and there is no documentation of altered sensation or weakness. Based on this information, the medical necessity of the requested electromyography (EMG) of the bilateral lower extremities is not established.

NCV Bilateral Lower Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines- treatment for Workers Compensation, Online Edition Chapter, Low Back- Lumbar & Thoracic (Acute & Chronic)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Electrodiagnostic studies (EDS) Official Disability Guidelines (ODG) Low Back, EMGs (electromyography) Official Disability Guidelines (ODG) Low Back, Nerve Conduction Studies (NCS)

Decision rationale: Evidence-based guidelines do not recommend nerve conduction velocity studies for low back conditions. Radiculopathy is considered as a minimal justification most especially when symptoms are presumed to be on this basis. Therefore, the medical necessity of nerve conduction velocity (NCV) studies of the bilateral lower extremities is not established.