

<b>Case Number:</b>	CM13-0011148		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	04/11/2012
<b>Decision Date:</b>	03/24/2014	<b>UR Denial Date:</b>	07/29/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/14/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine 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 physician 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 patient is a 38-year-old male with date of injury on 04/01/2012. The progress report dated 07/11/2013 by [REDACTED] indicates that the patient's diagnoses include: (1) Cervical herniated disk, (2) Lumbar herniated disk. The patient continues with low back and bilateral leg pain. The patient rates the pain at an 8/10 and is not getting better. Exam findings indicate plantarflexors and dorsiflexors are weak, rated at 4/5 bilaterally. It was noted that this has worsened since last visit. Sensation is decreased the level of L4 and L5 distribution on the right side. There is restricted range of motion of the lumbar spine. It was noted that the patient had recently completed a course of non-operative care. A request was made for nerve conduction studies to assess the patient's neural structure for possible surgical intervention. Utilization review letter dated 07/29/2013 issued noncertification of this request. Lumbar MRI from 06/08/2012 indicated neuroforaminal compromise is estimated to be mild to moderate bilaterally at L5-S1 and mild on the left at L4-L5 from disk bulging with moderate right L4-L5 neuroforamen compromise from disk bulging and some bone spurring from mild facet arthropathy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**nerve conduction studies of the lower extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines ODG-TWC guidelines

**Decision rationale:** The patient continues with significant low back pain with radicular symptoms into the bilateral lower extremities. The patient's MRI findings from 06/08/2012 indicate neuroforaminal compromise rated at mild to moderate bilaterally at L5-S1, and mild on the left L4-L5 from disk bulging with moderate right L4-L5 neuroforamen compromise from disk bulging and some bone spurring from mild facet arthropathy was noted. ACOEM Guidelines page 303 states that EMG including H-reflex test may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms, lasting more than 3 or 4 weeks. ACOEM does not support NCS for low back and leg symptoms. It supports EMG with H-reflex testing only. NCS can be helpful in differentiating peripheral neuropathies or myelopathies, but these concerns are not mentioned by the treating physician. ODG Guidelines specifically do not recommend nerve conduction studies and says there is minimal justification performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. ODG further states that EMGs may be useful to obtain unequivocal evidence of radiculopathy after 1 month's conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious. The request for nerve conduction studies for the lower extremities does not appear to be reasonable and is not supported by the guidelines noted above. Therefore, recommendation is for denial.