

<b>Case Number:</b>	CM13-0013263		
<b>Date Assigned:</b>	12/11/2013	<b>Date of Injury:</b>	04/22/2013
<b>Decision Date:</b>	01/16/2014	<b>UR Denial Date:</b>	07/01/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/19/2013

### 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 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:

This patient is a 46-year-old female who reported an injury between dates 04/04/2003 and 04/22/2013 due to repetitive motion trauma of the neck. Evaluation of the patient with cervical spine x-rays noted that the cervical vertebra bodies were of normal height and alignment with the patient having limited range of motion on flexion and extension views without evidence of instability. The intervertebral disc spaces were preserved throughout and the small cervical ribs were identified. The facets were normally articulated and the prevertebral soft tissues were noted as normal. The patient also underwent x-rays of the lumbar spine on the same date with findings of a grade II anterolisthesis of 16 mm at L5-S1 with marked loss of disc height. No distinct instability was seen on flexion and extension views given the patient's large body habitus and somewhat limited penetration of the x-ray beam. The remainder of the intervertebral disc spaces were noted to be preserved with bilateral marked facet arthropathy at L5-S1 with suspected bilateral pars defects. There was osteophyte formation along the right aspect of the spine and at L1-2. The sacroiliac joints were unremarkable and the soft tissues revealed no abnormality. This patient is currently recommended to undergo 1 electromyography and nerve conduction velocity study of the right lower extremity due to complaints of low back pain and radiating symptoms to the right lower extremity, as well as radiating neck pain to the right upper extremity. Findings for the patient on physical examination noted that range of motion of the lumbar spine was moderately reduced secondary to pain with evidence of spinal vertebral tenderness at L4-S1 levels and lumbar myofascial tenderness was noted on palpation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 Electromyography and nerve conduction velocity study of the right lower extremity as an outpatient: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM - [https://www.acoempracguides.org/Cervical and Thoracic Spine](https://www.acoempracguides.org/Cervical%20and%20Thoracic%20Spine); Table 2, Summary of Recommendations, Cervical and Thoracic Spine Disorders

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): s 303-305.

**Decision rationale:** ACOEM Guidelines state that 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. The Official Disability Guidelines states that there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. While the documentation submitted for review indicates on x-rays of the lumbar spine with flexion and extension views that the patient has evidence of a grade II anterolisthesis of 16 mm at L5-S1 with marked loss of disc height, there is no evidence of distinct instability seen on flexion and extension views. Furthermore, the clinical notes submitted for review indicate the patient has complaints of low back pain radiating to the right lower extremity; however, the patient on physical examination has no sensory deficits and no motor deficits. The reference guidelines support recommendation for electrodiagnostic studies with EMG indicated for identification of focal neurological dysfunction. However, nerve conduction studies have minimal justification when the patient is presumed to have symptoms on the basis of radiculopathy. Given the above, the request for 1 electromyography and nerve conduction velocity study of the right lower extremity as an outpatient is not medically necessary and appropriate.