Case Number:	CM13-0061871		
Date Assigned:	12/30/2013	**Date of Injury:**	09/11/2012
Decision Date:	05/29/2014	**UR Denial Date:**	11/04/2013
Priority:	Standard	**Application Received:**	12/05/2013

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 Geriatric Medicine and is licensed to practice in New York. 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 39-year-old man with a date of injury of 9/11/12. He was seen by his primary treating physician on 10/22/13 with complaints of pain in his neck and mid/low back, left shoulder, elbow, wrist, and hand. He had some restriction in the range of motion of his cervical spine, with pain towards terminal range of motion. He had negative Spurling's and Adson's Test. He has slight range of motion limitiation in his left shoulder with pain and spasm in the trapezius musculature. He had a positive Supraspinatus and Neer's test. His elbow and wrist/hand range of motion were normal, with no pain to palpation. His thoracic and lumbar spine had slightly limited range of motion with tenderness to palpation in the paraspinal muscles of the lumbar spine. His gait was not antalgic and he could walk on his heels and toes. He had positive straight leg raises. His hip, knee and foot exams were normal. His strength and reflexes were normal and senory exam showed only diminished light touch in the left median and ulnar derve distribution. His diagnoses included lumbar spine strain, rule out lumbar radiculopathy; left shoulder subacromial inmpingement syndrome, rule out rotator cuff tear; left carpal and cubital tunnel syndrome; cervicothoracic spine strain, rule out cervica radiculopathy; and left medial epicondylitis. He underwent a lumbar electromyogram in 7/13 showing "no spontaneous activities in the distal innervated muscles of the lower extremities with increased membrane irritability and trace positive sharp waves in the left L5-S1 paraspinal muscles which could indicate lumbar radiculopathy at this level. He had no evidence of entrapment neuropathy on the left peroneal and tibal nerves." Included in the treatment plan were requests for updated electrodiagnostic testing of the upper and lower extremities. The EMG/NCV studies of the lower extremities are at issue in this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

ELECTROMYOGRAPHY (EMG) OF THE BILATERAL LOWER EXTREMITIES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-326.

Decision rationale: The MTUS/ACOEM Guidelines indicate that electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with low back symptoms, or both, lasting more than three (3) or four (4) weeks. They can identify low back pathology in disc protrusion. This injured worker has already had prior studies in 7/2013, which showed only minimal findings possibly indicating L5-S1 radiculopathy. There are no red flags on physical exam to warrant further imaging, testing, or referrals. The records do not support the medical necessity for repeat EMG of the bilateral lower extremities.

NERVE CONDUCTION VELOCITY (NCV) 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): 287-326.

Decision rationale: The MTUS/ACOEM Guidelines indicate that electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with low back symptoms, or both, lasting more than three (3) or four (4) weeks. They can identify low back pathology in disc protrusion. This injured worker has already had prior studies in 7/2013, which showed only minimal findings possibly indicating L5-S1 radiculopathy. There are no red flags on physical exam to warrant further imaging, testing, or referrals. The records do not support the medical necessity for repeat NCV of the bilateral lower extremities.