

<b>Case Number:</b>	CM14-0109387		
<b>Date Assigned:</b>	09/19/2014	<b>Date of Injury:</b>	10/03/2013
<b>Decision Date:</b>	10/17/2014	<b>UR Denial Date:</b>	06/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/14/2014

### 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 Family 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 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:

This is a 39-year-old female who reported an industrial injury on 10/3/2013, one (1) year ago, attributed to the performance of her usual and customary job tasks reported as setting a door down on a tea car, which slammed into a right ankle. The diagnosis was sprain/strain of the ankle. The treating physician indicated that on 11/7/2013, a fluoroscopy of the ankle revealed no acute fractures or osseous contusion. An MRI of the right ankle documented no evidence of acute traumatic injury with only mild chronic tendinopathy. The patient complained of intermittent right ankle, right knee and low back pain. The patient was reported to have lost 100 pounds and now weighs 250 pounds. The patient was prescribed Naprosyn and tramadol; the objective findings on examination documented no deformity or spasm of the lumbar spine; full range of motion lumbar spine; gait was symmetrical; SLR negative strength was 5/5; no acute inflammation in the right near right ankle; full range of motion of the ankle and forefoot to my: no evidence of CRPS. The diagnoses were right ankle strain, right knee strain, and lumbar strain. The treatment plan included nerve studies of the lower extremities; repeated MRI of the low back; weight unloading brace laterally, a Ritchie ankle brace, hot and cold wrap, a back brace, TENS unit, and Norflex 100 mg #60, Neurontin 600 mg #90, Tramadol extended release 150 mg #30, Trazodone 50 mg #60.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**EMG of Bilateral Lower Extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 298-301, 303, 340, 346, Chronic Pain Treatment Guidelines Page(s): 13-16, 80-84, 18, 49, 63, 65, 116. Decision based on Non-MTUS Citation Official Disability Guidelines, (ODG), Treatment Index, 12th Edition (web), 2014, Low Back Nerve Conduction Studies

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 3 Initial Approaches to Treatment, Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints Page(s): 48, 62, 178; 62, 261, 298, 303, 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back chapter EMG; NCS

**Decision rationale:** There is no objective evidence of any changes in the neurological status of the patient to warrant Electrodiagnostic studies of the bilateral lower extremities. The patient was diagnosed with an ankle sprain and there are no neurological deficits documented to warrant Electrodiagnostic studies. There are no demonstrated progressive neurological deficits to support the medical necessity of a bilateral lower extremity EMG/NCS with no documented neurological deficits. The patient was documented to have a normal neurological examination with no sensory deficits along a dermatomal pathway to the BLEs. There is no evidence of a nerve impingement radiculopathy; only a subjective radiculopathy. There were no demonstrated neurological deficits along a dermatomal distribution to the BLEs on examination to support the medical necessity of the requested BLE EMG/NCS. The patient was reported to have full strength and FROM to the lower extremities. The patient was not noted to have any changes in clinical status. The patient had some subjective complaints of pain, but no sensation issues below the knee. The sensation to the bilateral lower extremities was reported as intact. There were no documented objective findings on examination to support medical necessity. There is no demonstrated medical necessity for a BLE EMG/NCS for the management of this patient. There are no documented changes in the neurological status of the patient that would require Electrodiagnostic studies. The request for the authorization of the EMG/NCS of the bilateral lower extremities was not supported with any objective clinical findings that would demonstrate a change in the neurological status of the patient or demonstrate neurological deficits in the lower extremities. There are no documented neurological findings that would suggest a nerve entrapment neuropathy in the clinical documentation to the BLEs. The motor and sensory examination was documented to be normal. The EMG/NCS of the BLE is not demonstrated to be medically necessary, as there are no documented objective changes in the sensory deficits or neurological changes. An EMG/NCS of the lower extremities is not recommended by the CA MTUS or the ACOEM Guidelines updated lower back chapter for patients without significant leg pain or numbness. There is no demonstrated medical necessity for the requested bilateral lower extremity EMG/NCS screening examination.