

<b>Case Number:</b>	CM14-0139847		
<b>Date Assigned:</b>	09/08/2014	<b>Date of Injury:</b>	06/23/2010
<b>Decision Date:</b>	10/03/2014	<b>UR Denial Date:</b>	08/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/28/2014

### 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, 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 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 patient is a 45 year old female with an injury date of 06/23/10. The 07/28/14 progress report by [REDACTED] states that the patient presents with excruciating lower back pain radiating down to the bilateral legs with tingling and numbness in the bilateral big toe and second toe in distribution of L4 and L5 nerve roots. The patient states she did very well post-surgery. The treating provider notes S/P L5-S1 disc replacement in 2010 but it is unclear if this is the surgery to which the patient refers. Examination reveals sensation is decreased in bilateral L5 and S1 dermatomes. The 07/14/14 MRI of the lumbar spine reports the following findings: At L1-2 there is a 3 mm posterior disc bulge without central or lateral spinal stenosis. At L2-3 there is loss of nucleus pulposus signal intensity and a 3 mm disc bulge with mild central canal narrowing. At L3-4 there is a 2-3 mm disc bulge without central or lateral spinal stenosis. At L4-5 there is a 3 to 4 mm posterior disc bulge with mild bilateral facet hypertrophy and mild left neural foraminal narrowing. No significant central canal narrowing is present. At L5-S1 there is paramagnetic artifact obscuring the disc in the sagittal plane. There is moderate to severe right facet hypertrophy. Artifact obscures the central canal in the axial plane to large extent. However, no significant central canal narrowing is identified. Artifact also obscures the neural foramina. A CT with multiplanar reformations may be helpful to assess the L5-S1 level. Intervertebral fusion may be present at this level. The patient's diagnoses are lower back pain with bilateral radiculopathy with mild L4-5 foraminal stenosis. The utilization review being challenged is dated 08/25/14. Treatment reports were provided from 06/23/14 to 08/06/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**EMG/NCS Bilateral Lower Extremities:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back Chapter EMG's

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG under low back-lumbar & thoracic (acute and chronic) Nerve conduction studies (NCS

**Decision rationale:** The treating provider requests for EMG/NCS bilateral lower extremities to help with assessment. MTUS and ACOEM do not discuss NCS. However, ODG guidelines have the following regarding NCV studies: Not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. (Utah, 2006) This systematic review and meta-analysis demonstrate that neurological testing procedures have limited overall diagnostic accuracy in detecting disc herniation with suspected radiculopathy. (Al Nezari, 2013)" In this case the patient presents with low back and leg symptoms. While EMG may be indicated, NCV studies are not supported if the leg symptoms are presumed to be coming from the lumbar spine. However, there is no evidence that the patient has electrical studies done in the past and given the diagnostic possible confusion, recommendation is for medical necessity.