

<b>Case Number:</b>	CM14-0023510		
<b>Date Assigned:</b>	05/12/2014	<b>Date of Injury:</b>	06/19/2008
<b>Decision Date:</b>	07/30/2014	<b>UR Denial Date:</b>	02/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/24/2014

### 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 Occupational 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 61-year-old female patient with a 6/19/08 date of injury. The mechanism of injury was not provided. A 1/30/14 progress report indicated that the patient complained of the pain on the neck, lower back and bilateral knees radiated to the lower extremity with numbness and tingling. Objective findings demonstrated decreased range of motion. There was tenderness over the lumbar paraspinal musculature with spasm and tightness, and hypoesthesia on the bilateral lower extremities at L5-S1 dermatome distribution. The treatment plan revealed that the patient needed further diagnostic studies as per award, therefore she requested for electromyography (EMG)/ NCV (nerve conduction velocity) of bilateral lower extremity to establish the presence of radiculitis/ neuropathy. A 04/24/14 progress report indicated that the patient complained of pain in the lower back, bilateral knees and bilateral shoulders, 9/10. Physical exam was almost the same as on 1/30/14. The patient was diagnosed with segmental instability spondilolisthesis at L4-5, herniated lumbar disc L4-5, L5-S1 with radiculopathy left greater than right, laminectomy, and foraminotomy. She was also diagnosed with left knee sprain, right knee sprain, cervical spine sprain and bilateral shoulder sprain. MRI (magnetic resonance imaging) and x-ray results were not available in the medical records. The treatment to date: medication management and physical therapy. There is documentation of a previous 2/7/14 adverse determination. The rationale for denial was not provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Electromyography (EMG) of bilateral lower extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Electromyography (EMG)/ NCV (nerve conduction velocity).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter.

**Decision rationale:** The CA MTUS states that electromyography (EMG), including H-reflex tests, are indicated to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three to four weeks. In addition, the Official Disability Guidelines (ODG) states that EMGs may be useful to obtain unequivocal evidence of radiculopathy, after one-month conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious. Furthermore, EMG are not recommended when a patient is presumed to have symptoms on the basis of radiculopathy. However, there was documentation supporting radicular pain in the lower extremities as the pain radiated from the lumbar spine to the lower extremities. In addition, there was evidence of hypoesthesia on the bilateral lower extremities at L5-S1 dermatome distribution. The ODG does not support EMG if radiculopathy is already clinically obvious. Therefore, the request for electromyography (EMG) bilateral lower extremities is not medically necessary.

**NCV (nerve conduction velocity) of bilateral lower extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Electromyography (EMG)/ NCV (nerve conduction velocity).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter.

**Decision rationale:** The CA MTUS states that NCV (nerve conduction velocity), including H-reflex tests, are indicated to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three to four weeks. In addition, the Official Disability Guidelines (ODG) states that NCV may be useful to obtain unequivocal evidence of radiculopathy, after one-month conservative therapy, but NCVs are not necessary if radiculopathy is already clinically obvious. Furthermore, NCV are not recommended when a patient is presumed to have symptoms on the basis of radiculopathy. However, there was documentation supporting radicular pain in the lower extremities as the pain radiated from lumbar spine to the lower extremities. In addition, there was evidence of hypoesthesia on the bilateral lower extremities at L5-S1 dermatome distribution. The ODG does not recommend NCV if the patient is presumed to have symptoms on the basis of radiculopathy. Therefore, the request for nerve conduction velocity (NCV) bilateral lower extremities is not medically necessary.

