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| **Case Number:** | CM14-0065048 | | |
| **Date Assigned:** | 07/16/2014 | **Date of Injury:** | 02/15/2010 |
| **Decision Date:** | 10/01/2014 | **UR Denial Date:** | 04/29/2014 |
| **Priority:** | Standard | **Application Received:** | 05/08/2014 |

## 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 Internal 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:

The injured worker was a 45 year old woman who reportedly suffered low back pain due to chronic sitting at work associated with repetitive trauma. She was seen in February, March and April 2014 by the primary treating provider. The request for EMG/NCV of bilateral lower extremities was requested on 4/15/2014. According to visit notes taken cumulatively, the patient has low back pain, pain at bilateral sacro-iliac joints, radicular pain in the lower extremities with a burning quality, "like fire" around the toes. She has low back tenderness, paraspinal muscle spasm and SI joint tenderness bilaterally. There is reported left straight leg raising test positive. Sensation is intact and knee flexors and extensors are bilaterally 4/5 although there is giveaway documented by the provider. The patient had an MRI of the lower back in 2010 documenting mild L2-L3 disk degeneration without disk displacement or neural foraminal narrowing. An EMG of both lower extremities done previously in May 2012 demonstrated delayed onset latencies in the context of piriformis muscle stretching. Otherwise, that study was entirely normal, with no evidence of lumbar or lumbo-sacral radiculopathy or plexopathy. No mononeuropathies of lower extremities were noted at that time.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**EMG Bilateral lower extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-303.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Pain / Low Back / Chronic: Electrodiagnostic studies "In the Low Back Chapter and Neck Chapter, it says NCS is not recommended, but EMG is recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious." Other Medical Treatment Guideline or Medical Evidence: http://www.webmd.c

**Decision rationale:** Nerve conduction studies are typically recommended when neuropathic symptoms suggest a mononeuropathy or polyneuropathy in the limbs. The patient's complaints of stretch related onset of pain in the lower extremities is not consistent with a mononeuropathy or polyneuropathy. There is no objective evidence in terms of specific muscle groups or motor units (muscles supplied by a single nerve) being specifically compromised. There was giveaway on examination and that suggests the examination is not reliable and patient may not be providing full effort in terms of motor examination. The sensory examination has been documented to be normal in multiple clinical notes. Therefore, there is no reason to pursue a bilateral nerve conduction study. In terms of an EMG, the patient has already had an EMG in 2012 and the diagnosis was stretch related radiculopathic / neuropathic pain generated at the level of the piriformis muscle. The radiation of this pain along the back of the leg and into the toes is highly suggestive of a continuation of this pathology of piriformis muscle spasm and resultant impingement of the Sciatic nerve as it passes through the obturator foramen in the pelvis ("piriformis syndrome"), particularly in certain positions and upon stretch of the piriformis. As the diagnosis is highly suggested by clinical presentation and previous EMG, and the symptoms are consistent with the same pathology of piriformis syndrome that was present previously on EMG, there are NO NEW FINDINGS to suggest the need for an additional EMG. Also, since the NCV component of the study is not necessary or recommended (as indicated above), the request for bilateral EMG/NCV is recommended as not medically necessary.

**NCS Bilateral lower extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-303.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Section - Pain (Chronic), Topic - Electrodiagnostic Studies. Other Medical Treatment Guideline or Medical Evidence: http://www.webmd.com/pain-management/guide/piriformis-syndrome-causes-symptoms-treatments, accessed 9/28/2014.

**Decision rationale:** Nerve conduction studies are typically recommended when neuropathic symptoms suggest a mononeuropathy or polyneuropathy in the limbs. The patient's complaints of stretch related onset of pain in the lower extremities is not consistent with a mononeuropathy or polyneuropathy. There is no objective evidence in terms of specific muscle groups or motor units (muscles supplied by a single nerve) being specifically compromised. There was giveaway on examination and that suggests the examination is not reliable and patient may not be providing

full effort in terms of motor examination. The sensory examination has been documented to be normal in multiple clinical notes. Therefore, there is no reason to pursue a bilateral nerve conduction study. In terms of an EMG, the patient has already had an EMG in 2012 and the diagnosis was stretch related radiculopathic / neuropathic pain generated at the level of the piriformis muscle. The radiation of this pain along the back of the leg and into the toes is highly suggestive of a continuation of this pathology of piriformis muscle spasm and resultant impingement of the Sciatic nerve as it passes through the obturator foramen in the pelvis ("piriformis syndrome"), particularly in certain positions and upon stretch of the piriformis. As the diagnosis is highly suggested by clinical presentation and previous EMG, and the symptoms are consistent with the same pathology of piriformis syndrome that was present previously on EMG, there are NO NEW FINDINGS to suggest the need for an additional EMG. Also, since the NCV component of the study is not necessary or recommended (as indicated above), the request for bilateral EMG/NCV is recommended as not medically necessary.