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| **Case Number:** | CM14-0070228 | | |
| **Date Assigned:** | 07/14/2014 | **Date of Injury:** | 01/26/2012 |
| **Decision Date:** | 09/10/2014 | **UR Denial Date:** | 04/18/2014 |
| **Priority:** | Standard | **Application Received:** | 05/15/2014 |

## 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 Neuromuscular Medicine and is licensed to practice in Maryland. 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 50 year old male with a work injury dated. The diagnoses include herniated nucleus pulposus on the left at L5-S1; radiculopathy/radiculitis of the left lower extremity; degenerative disc disease; depression; erectile dysfunction; left sacroiliitis; insomnia as a result of the pain from the industrial injury. Under consideration is a request for EMG Bilateral Lower Extremities. There is a utilization review report dated 5/13/14 that states that the patient does continue to have low back pain that is radiating down his left lower extremity all the way down to the foot with associated numbness and tingling. He states that the pain radiates to the bottom of his left heel. The patient was referred for a surgical consultation. Surgery was a possibility; however, patient did not wish to proceed with surgery. He would like to stay conservative with his treatment. He has had physical therapy, aquatic therapy and massage therapy. They helped temporarily, but he remains symptomatic. The patient did continue working after his industrial injury but his pain condition gradually worsened. He eventually went off work in June 2013. He has not worked since then. A previous physical exam revealed that the patient's gait was antalgic. The patient ambulated into the room without any assistance. Examination of the lumbar spine reveals tenderness to palpation at the lumbosacral junction. Range of motion of lumbar spine is decreased by 30% with flexion, 40% with extension and 40% with rotation to the left and 20% with rotation to the right. Sensations are decreased along the left calf compared to the right lower extremity. Motor strength is 4/5 with left leg extension and left foot dorsiflexion compared to right lower extremity. Deep tendon reflexes are 2+ and equal at the patella and Achilles. Clonus is negative bilaterally. Straight leg raise is positive at about 50" at the left lower extremity. The MRI of the lumbar spine from 7/25/13 demonstrates an L5-S1 5 mm disc protrusion left paracentral and centrally displacing the left S1 nerve root in contact. It is impinging on the nerve

root and displacing it. The discussion states that the patient continues to have intractable low back pain. His low back pain does radiate down into his left lower extremity all the way down to the foot with associated numbness and tingling. On objective examination, decreased sensations along the left calf compared to the light lower extremity. His motor strength is also reduced with left leg extension, and left foot dorsiflexion compared to right lower extremity. He has a straight leg raise positive at about 50 at the left lower extremity. The document indicates that an EMG/NCS is indicated to evaluate the severity to rule out any active denervation. There could be evidence of nerve damage and the EMG would help us in guiding the next steps. EMG/NCV is also required to isolate the level of nerve initiation or injury. Furthermore, the patient has weakness with left leg extension and left foot dorsiflexion. The document states that an EMG is indicated which will help us to distinguish between muscle conditions in which the problem begins in the muscle and muscle weakness due to nerve disorders. Please note that although there are no symptoms in the right lower extremity, EMG of the right lower extremity is warranted for comparison and this will serve as a control to rule out pathology on the right side.

## 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 Chapter 3 Initial Approaches to Treatment Page(s): 303,Chronic Pain Treatment Guidelines Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines.

**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, EMGs (electromyography); Nerve conduction studies (NCS).

**Decision rationale:** Electromyography (EMG) of the bilateral lower extremities is not medically necessary per the Official Disability Guidelines (ODG) and the MTUS guidelines. The MTUS ACOEM guidelines state that when the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. The Official Disability Guidelines states that an EMG is recommended as an option (needle, not surface). EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. The Official Disability Guidelines also states that there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. The documentation does not indicate RLE symptoms therefore there is no need to perform and EMG on the RLE. Furthermore the history and physical are clear that this is a radicular process and therefore the Official Disability Guidelines states that EMG's are not necessary if radiculopathy is already clinically obvious. Therefore, this request is not medically necessary.