

<b>Case Number:</b>	CM14-0043061		
<b>Date Assigned:</b>	06/30/2014	<b>Date of Injury:</b>	10/15/2013
<b>Decision Date:</b>	02/03/2015	<b>UR Denial Date:</b>	04/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/09/2014

### 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 Neurology, has a subspecialty in Neuromuscular Medicine, and is licensed to practice in New Jersey. 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 42-year-old man who sustained a work-related injury on October 15, 2013. Subsequently, she developed chronic low back pain. MRI of the lumbar spine dated December 11, 2013 showed a 2-3 mm disc bulge at L4-5. An EMG/NCV study of the lumbar spine and lower extremities performed on February 13, 2014 documented normal EMG study of the lower extremities with no acute or chronic denervation potentials and normal NCV study of the lower extremities. It did not reveal ant electrophysiological evidence of peripheral nerve entrapment. Prior treatments included: medications, acupuncture, and physical therapy treatment. According to the progress report dated March 24, 2014, the patient complained of on-and-off lower back pain, which was rated as moderate to occasionally severe. He stated he had worsening radiation to the left leg, left thigh, left hamstring, left knee, left calf, left heel, and left foot. There was numbness and tingling sensation only on the left calf. The patient also complained of persistent insomnia secondary to the leg discomfort. Physical examination revealed tenderness to palpation with spasm of the paraspinals and left gluteal and tenderness to palpation of the left sacroiliac. He had limited range of motion secondary to pain. There was positive sitting root. He had hypesthesia of the left posterior thigh and left posterior portion of his calf. Patellar L4 was 3+ and Achilles S1 were 2+. The patient was diagnosed with lumbar spine sprain/strain, lumbar radiculopathy, lumbar spine myospasms, and multi-level disc protrusions of the lumbar spine. The provider requested authorization for bilateral lower extremity EMG/NCV study.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **Bilateral Lower Extremity EMG/NCV Study: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints  
Page(s): 303-304.

**Decision rationale:** According to MTUS guidelines, needle EMG study helps identify subtle neurological focal dysfunction in patients with neck and arm symptoms. << When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with low back symptoms, lasting more than three or four weeks>> (page 303). EMG is indicated to clarify nerve dysfunction in case of suspected disc herniation (page 182). EMG has a high technical ability to identify lower back disc bulging.(page 304). EMG is not recommended if the diagnosis of radiculopathy is obvious clinically. In this case, there is no clinical evidence of signs of lumbar radiculopathy, sensory or motor neuropathy. There is no signs of subtle neurologic dysfunction that may be identified by NCV/EMG. There is no signs of clinical changes from the previous EMG/NCV study. Based on the above, the bilateral lower extremity EMG/NCV is not medically necessary.