Case Number:	CM15-0136916		
Date Assigned:	07/24/2015	**Date of Injury:**	06/18/2014
Decision Date:	08/25/2015	**UR Denial Date:**	06/19/2015
Priority:	Standard	**Application Received:**	07/15/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California
Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 36 year old female sustained an industrial injury to the back on 6/18/14. Magnetic resonance imaging lumbar spine (4/21/15) showed a transitional lumbosacral S1 vertebral body and disc protrusion with central stenosis at L5-S1. Previous treatment included physical therapy, chiropractic therapy, acupuncture, home exercise and medications. In a PR-2 dated 3/9/15, the injured worker complained of ongoing pain to the lumbar spine rated 6-7/10 on the visual analog scale. The injured worker had been approved for lumbar epidural steroid injections but had cancelled a scheduled appointment for the third time. The injured worker was released from the physician's care without any limitations, restrictions, ratable disability or need for future medical care. In a PR-2 dated 6/19/15, the injured worker complained of constant low back pain rated 5/10 on the visual analog scale with radiation to the right lower extremity associated with numbness and tingling. Physical exam was remarkable for tenderness to palpation over the lumbar spine with negative bilateral straight leg raise and decreased range of motion. Current diagnoses included lumbar spine radiculopathy. The treatment plan included dispensing Theramine and Sentra Am, a one month trial of a transcutaneous electrical nerve stimulator unit, a urine drug screen and continuing home exercise.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electromyography and Nerve conduction velocity studies of the bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

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, Electrodiagnostic Studies.

Decision rationale: With regard to EMG/NCS of the lower extremities to evaluate for lumbar radiculopathy, Section 9792.23.5 of the California Code of Regulations, Title 8, page 6 adopts ACOEM Practice Guidelines Chapter 12. ACOEM Chapter 12 on page 303 states: "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 update to ACOEM Chapter 12 Low Back Disorders on pages 60-61 further states: "The nerve conduction studies are usually normal in radiculopathy (except for motor nerve amplitude loss in muscles innervated by the involved nerve root in more severe radiculopathy and H-wave studies for unilateral S1 radiculopathy). Nerve conduction studies rule out other causes for lower limb symptoms (generalized peripheral neuropathy, peroneal compression neuropathy at the proximal fibular, etc.) that can mimic sciatica." Further guidelines can be found in the Official Disability Guidelines. The Official Disability Guidelines Low Back Chapter, states the following regarding electromyography: "Recommended as an option (needle, not surface). EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious. (Bigos. 1999) (Ortiz-Corredor. 2003) (Haig. 2005) EMGs may be required by the AMA Guides for an impairment rating of radiculopathy. (AMA 2001)" With regard to nerve conduction studies, the Official Disability Guidelines Low Back Chapter states: "Nerve conduction studies (NCS) section: 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)" However, it should be noted that this guideline has lower precedence than the ACOEM Practice Guidelines which are incorporated into the California Medical Treatment and Utilization Schedule, which do recommend NCS. Therefore, nerve conduction studies are recommended in evaluations for lumbar radiculopathy. Within the documentation available for review, there is clear documentation to support lumbar radiculopathy. Subjectively the patient complains of low back radiating to the legs, and there is positive straight leg raise on exam. The lumbar MRI does indicate at a disc bulge at L5-S1. At this juncture it is not clear what would be gained by electrodiagnostic testing. The guidelines specify that NCS is not indicated in cases where radiculopathy is clinically obvious. Given this, the current request is not medically necessary.