

<b>Case Number:</b>	CM15-0138621		
<b>Date Assigned:</b>	07/28/2015	<b>Date of Injury:</b>	12/01/2013
<b>Decision Date:</b>	08/27/2015	<b>UR Denial Date:</b>	07/01/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/17/2015

### 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:

The injured worker is a 47-year-old male, who sustained an industrial injury on 12/01/2013, due to cumulative trauma while employed as a dock worker and delivery driver. He reported a flare of lumbar pain when attempting to pick up his motorcycle. The injured worker was diagnosed as having L3-L4 disc herniation and discogenic back pain. His past medical history included diabetes and hypertension. Treatment to date has included diagnostics, epidural steroid injections and medications. On 6/10/2015, the injured worker complained of lumbar spine pain, rated 5/10, and a request for an alteration in restrictions. He was previously without restrictions but was unable to perform his duties. Exam of his lumbar spine noted decreased range of motion and mildly positive paraspinal tenderness to percussion. His work status was modified. Current medication regimen was not noted. The treatment plan included electromyogram and nerve conduction studies of the lower extremities.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**EMG/ NCV bilateral lower extremities for lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 293-303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 13th Edition (web) 2015, Low Back Chapter.

**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 lack of a full neurologic examination documenting abnormalities in the sensory, motor, or deep tendon reflex systems to support a diagnosis of specific nerve compromise. The progress notes around the time of this request did not document these neurologic abnormalities to support the need for this request. The only finding is a positive straight leg raise test. It should be noted the EMG/NCS have good specificity but poor sensitivity for detecting lumbar radiculopathy unless significant motor fibers are involved. Given this, the current request is not medically necessary.