Case Number:	CM15-0140561		
Date Assigned:	07/30/2015	**Date of Injury:**	08/26/2014
Decision Date:	09/15/2015	**UR Denial Date:**	07/13/2015
Priority:	Standard	**Application Received:**	07/20/2015

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 58 year old male sustained an industrial injury to the head, ribs, facial bone, neck and low back on 8-26-14. The injured worker sustained multiple acute fractures to the facial bones and ribs. Magnetic resonance imaging of the brain showed encephalomalacia in the posterior left frontal and temporal lobes. Magnetic resonance imaging cervical spine (11-13-14) showed multilevel spondylosis with central canal stenosis and neuroforaminal stenosis. In a PR-2 dated 7/6/15, the injured worker reported increasing loss of bowel and bladder control over the past three months. The injured worker complained of worsening, daily, severe headaches and fatigue. The injured worker also complained of progressively worsening low back pain with radiation into the right leg. The injured worker stated that he had two incidents in the last 90 days where he lost control of his bowel and bladder. Current diagnoses included extensive facial fractures, liver laceration, maxillary sinus fracture, open nasal bone fracture, rib fractures, scalp laceration, lumbar degenerative disc disease, cervical pain, memory loss, new onset tinnitus, blurred vision, traumatic brain injury, encephalomalacia, ophthalmic migraine, cervical spine stenosis, cervical spine degenerative disc disease and nausea. The physician noted that the injured worker had been referred for a neurology consultation but required a work-up before his appointment. The treatment plan included referrals for magnetic resonance imaging lumbar spine and electromyography bilateral lower extremities and continuing medications (Propanolol and Topamax).

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG left lower extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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, EMGs, Electrodiagnostic Studies.

Decision rationale: Regarding the request for EMG of the lower extremity, ACOEM Chapter 12 states that electromyography, include H-reflex tests, may be useful to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than 3 to 4 weeks. The electromyography component of electrodiagnostic testing is in fact the primary component in detecting lumbar radiculopathy. ODG further specify that EMGs are "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." Within the documentation available for review, there are no physical examination findings supporting a diagnosis of specific nerve compromise. The progress notes from April to June 2015 document normal ROM on musculoskeletal exam, and there are no focal findings or significant neurologic findings. In the absence of such documentation, the currently requested EMG of the lower extremity is not medically necessary.

NCV left lower extremity: 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, Nerve conduction studies (NCS).

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, Nerve Conduction Studies, Electrodiagnostic Studies.

Decision rationale: With regard to the request for NCS of the left lower extremity, 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." Note that these guidelines supersede those of the ODG, which recommend against NCS for low back pathology, since the ACOEM is directly adopted by the CA MTUS. Therefore, nerve conduction studies are recommended in evaluations for lumbar radiculopathy. In the case of this injured worker, there is documentation of MRI findings including neuroforaminal stenosis, which could result in mechanical impingement of nerve roots. However, there is a lack of exam findings to indicate a neurologic issue. Specifically, the notes from April to June 2015 fail to

document any abnormalities in neurologic exam. There is no motor or sensory exam on the lower extremities carried out. Gait is noted to be antalgic, but this in it of itself does not warrant NCS testing. Given this, this request is not medically necessary.

EMG right lower extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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, EMGs, Electrodiagnostic Studies.

Decision rationale: Regarding the request for EMG of the right lower extremity, ACOEM Chapter 12 states that electromyography, include H-reflex tests, may be useful to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than 3 to 4 weeks. The electromyography component of electrodiagnostic testing is in fact the primary component in detecting lumbar radiculopathy. ODG further specify that EMGs are "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." Within the documentation available for review, there are no physical examination findings supporting a diagnosis of specific nerve compromise. Additionally, if such findings are present but have not been documented, there is no documentation that the patient has failed conservative treatment directed towards these complaints. Given this, the current request is not medically necessary.

NCV right lower extremity: 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, Nerve conduction studies (NCS).

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, Nerve Conduction Studies, Electrodiagnostic Studies.

Decision rationale: With regard to the request for NCS of the right lower extremity, 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." Note that these guidelines supersede those of the ODG, which recommend against NCS for low back pathology, since the ACOEM is directly adopted by the CA MTUS. Therefore, nerve conduction studies are recommended in evaluations for lumbar radiculopathy. In the case of this injured worker, there is documentation of MRI findings including neuroforaminal stenosis, which could result in mechanical impingement of nerve roots. However, there is a lack of exam findings to indicate a neurologic issue. Specifically, the notes

from April to June 2015 fail to document any abnormalities in neurologic exam. There is no motor or sensory exam on the lower extremities carried out. Gait is noted to be antalgic, but this in it of itself does not warrant NCS testing. Given this, this request is not medically necessary.