

|                       |              |                              |            |
|-----------------------|--------------|------------------------------|------------|
| <b>Case Number:</b>   | CM15-0143267 |                              |            |
| <b>Date Assigned:</b> | 08/04/2015   | <b>Date of Injury:</b>       | 02/01/2012 |
| <b>Decision Date:</b> | 09/15/2015   | <b>UR Denial Date:</b>       | 06/25/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 07/23/2015 |

### 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 38-year-old male, who sustained an industrial injury on February 01, 2012. The injured worker reported falling approximately five feet sustaining injuries to the low back, the left knee, the left ankle, and the left thumb. The injured worker was diagnosed as having lumbosacral sprain and strain, disc protrusions at lumbar four to five and lumbar five to sacral one, lateral recess stenosis at lumbar four to five, lumbar facet syndrome, left sacroiliac sprain, and left knee internal derangement with medial meniscal tear, status post arthroscopic repair with recurrent tear, and rule out anterior cruciate ligament tear. Treatment and diagnostic studies to date has included electromyogram with nerve conduction velocity of the bilateral lower extremities, lumbar transforaminal epidural steroid injection, laboratory studies, magnetic resonance imaging of the lumbar spine, magnetic resonance arthrogram of the left knee, status post left knee medial meniscectomy, and medication regimen. In a progress note dated June 17, 2015 the treating physician reports complaints of constant pain to the back along with numbness to the left buttock and the posterior thigh region. The treating physician also noted constant pain to the left knee. Examination reveals decreased range of motion to the lumbosacral spine and the left knee with pain, tenderness to the lumbar spine from lumbar four to sacral one, tenderness to the left paralumbar muscles, tenderness to the bilateral sacroiliac joints, tenderness to the medial joint line and the femoral condyle of the left knee, and hyperesthesia to the left leg in a non-dermatomal distribution. The injured worker's pain level was rated an 8 to 9 out of 10 to the back without the use of the injured worker's medication regimen that decreases to a 5 out of 10 with the use of his medication regimen. The injured worker's pain level to the left knee was rated

an 8 out of 10 without the use of his medication regimen and rates the pain a 5 to 6 out of 10 with the use of his medication regimen. The treating physician noted magnetic resonance imaging from November 21, 2013 that was revealing for disc protrusion at lumbar four to five with moderate narrowing of the lateral recesses bilaterally and separation at the facet joints along with lumbar five to sacral one disc protrusion with significant narrowing four the left lateral recess and separation of the facet joints. The medical records provided contained documentation of electromyogram with nerve conduction velocity performed on August 11, 2014 that was revealing for possible left sacral one radiculopathy. The treating physician requested electromyogram of bilateral lower extremities with nerve conduction velocity of the bilateral lower extremities as recommended in a qualified medical evaluation to assess for positive findings and to recommend lumbar epidural steroid injections and possible surgery if the findings are positive. Notes indicate that the patient may have undergone a 2nd EMG/NCV of the lower extremities as well.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**EMG of 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), Pain (Chronic) 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:** Regarding the request for EMG of the right lower extremity, Occupational Medicine Practice Guidelines state that unequivocal objective findings that identify specific nerve compromise on the neurologic exam are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery. When a neurologic examination is less clear however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. They go on to state that electromyography may be useful to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than 3 to 4 weeks. ODG states that nerve conduction studies are not recommended for back conditions. They go on to state that there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Electrodiagnostic study and possibly 2. There is no documentation indicating how the patient's symptoms and findings have changed since the time of the most recent electrodiagnostic studies. Additionally, within the documentation available for review, it appears the patient has undergone at least one is unclear how the current treatment plan will be changed based upon the outcome of the current diagnostic studies. Notes indicate that there is consideration for an epidural injection, but it appears that this is already been performed. In the absence of clarity regarding those issues, the currently requested EMG of the right lower extremity is not medically necessary.

**EMG of the 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), Pain (Chronic) 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:** Regarding the request for EMG of the left lower extremity, Occupational Medicine Practice Guidelines state that unequivocal objective findings that identify specific nerve compromise on the neurologic exam are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery. When a neurologic examination is less clear however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. They go on to state that electromyography may be useful to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than 3 to 4 weeks. ODG states that nerve conduction studies are not recommended for back conditions. They go on to state that there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Electrodiagnostic study and possibly 2. There is no documentation indicating how the patient's symptoms and findings have changed since the time of the most recent electrodiagnostic studies. Additionally, within the documentation available for review, it appears the patient has undergone at least one is unclear how the current treatment plan will be changed based upon the outcome of the current diagnostic studies. Notes indicate that there is consideration for an epidural injection, but it appears that this is already been performed. In the absence of clarity regarding those issues, the currently requested EMG of the left lower extremity is not medically necessary.

**NCV of the 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), Pain (Chronic) 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:** Regarding the request for NCV of the right lower extremity, Occupational Medicine Practice Guidelines state that unequivocal objective findings that identify specific nerve compromise on the neurologic exam are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery. When a neurologic examination is less clear however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. They go on to state that electromyography may be useful to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than 3 to 4 weeks. ODG states that nerve conduction studies are not recommended for back conditions. They go on to state that there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Electrodiagnostic study and possibly 2. There is no documentation indicating how the patient's symptoms and findings have changed since the time of the most recent electrodiagnostic studies. Additionally, within the documentation available for review, it appears the patient has undergone at least one is unclear how the current treatment plan will be changed based upon the

outcome of the current diagnostic studies. Notes indicate that there is consideration for an epidural injection, but it appears that this is already been performed. In the absence of clarity regarding those issues, the currently requested NCV of the right lower extremity is not medically necessary.

**NCV of the 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), Pain (Chronic) 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:** Regarding the request for NCV of the left lower extremity, Occupational Medicine Practice Guidelines state that unequivocal objective findings that identify specific nerve compromise on the neurologic exam are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery. When a neurologic examination is less clear however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. They go on to state that electromyography may be useful to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than 3 to 4 weeks. ODG states that nerve conduction studies are not recommended for back conditions. They go on to state that there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Electrodiagnostic study and possibly 2. There is no documentation indicating how the patient's symptoms and findings have changed since the time of the most recent electrodiagnostic studies. Additionally, within the documentation available for review, it appears the patient has undergone at least one is unclear how the current treatment plan will be changed based upon the outcome of the current diagnostic studies. Notes indicate that there is consideration for an epidural injection, but it appears that this is already been performed. In the absence of clarity regarding those issues, the currently requested NCV of the left lower extremity is not medically necessary.