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| **Case Number:** | CM15-0162246 | | |
| **Date Assigned:** | 08/28/2015 | **Date of Injury:** | 05/29/2014 |
| **Decision Date:** | 09/30/2015 | **UR Denial Date:** | 07/27/2015 |
| **Priority:** | Standard | **Application Received:** | 08/18/2015 |

## 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: North Carolina
Certification(s)/Specialty: Family Practice

## 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 29 year old male who sustained an industrial-work injury on 5-29-14. He reported an initial complaint of back, hand, wrist pain. The injured worker was diagnosed as having chronic low back pain with lumbar myofascial syndrome, tenosynovitis of hand-wrist, bilateral impingement syndrome, and bilateral carpal tunnel syndrome. Treatment to date includes medication and physical therapy. MRI results were reported on 4-2-15 that demonstrated a right lateral broad-based protrusion at the L5-S1 level contacting the L5 nerve root and resulting in moderate proximal right foraminal narrowing and no central canal stenosis. X-ray results were reported on 6-25-14 of the cervical and lumbar spine that were negative. EMG-NCV (electromyography and nerve conduction velocity test) was done on 4-14-15 that demonstrated moderate bilateral carpal tunnel syndrome. Currently, the injured worker complained of low back pain with radiation down both legs, including numbness in the right lateral calf and foot and occasional sense of weakness in the right leg. Per the primary physician's report (PR-2) on 7-21-15, exam of the lumbar spine noted tenderness with palpation, pain on flexion, diminished right great toe dorsiflexion, and decreased range of motion, normal sensation, and negative straight leg raise. The requested treatments include EMG (electromyelogram) and NCS (nerve conduction studies) of bilateral lower extremities.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**EMG and NCS bilateral lower extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Lumbar & Thoracic Chapter.

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

**Decision rationale:** The ACOEM chapters on low back complaints and the need for lower extremity EMG/NCV states: Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures). 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. There are unequivocal objective findings of nerve compromise on the neurologic exam provided for review. However there is not mention of surgical consideration. There are no unclear neurologic findings on exam. For these reasons, criteria for lower extremity EMG/NCV have not been met as set forth in the ACOEM. Therefore the request is not medically necessary.