

<b>Case Number:</b>	CM15-0184545		
<b>Date Assigned:</b>	09/25/2015	<b>Date of Injury:</b>	06/04/2015
<b>Decision Date:</b>	11/02/2015	<b>UR Denial Date:</b>	09/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/19/2015

### 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 22 year old male, who sustained an industrial injury on 6-4-2015. The injured worker was being treated for lumbosacral joint-ligament sprain and strain and lumbar degenerative disc disease. On 8-27-2015, the injured worker reported continued low back pain radiating to the lower extremities with numbness and tingling. His pain was constant and rated 7. Taking his medication was the only time his pain was calmed. He reported physical therapy and acupuncture were mildly helpful. The physical exam revealed decreased lumbar range of motion, tenderness to palpation in the lumbar paraspinal muscles, and diffuse pain of the right hip. On 8-20-2015, an MRI of the lumbar spine revealed a L5-S1 (lumbar 5-sacral 1) partial disc herniation and posterior central disc protrusion of almost 4 millimeter with slight extension over the S1 endplate. Treatment has included physical therapy, acupuncture, therapeutic self-massage, work restrictions, ultrasound therapy, a transcutaneous electrical nerve stimulation (TENS) unit, and medications including oral pain (Oxycodone-Acetaminophen), topical pain (Lidopro cream), anti-epilepsy (Gabapentin), muscle relaxant (Cyclobenzaprine), proton pump inhibitor (Omeprazole), and non-steroidal anti-inflammatory (Ibuprofen). Per the treating physician (8-17- 2015 report), the injured worker is not working as his employer cannot accommodate his work restriction. On 8-27-2015, the requested treatments included electromyography and nerve conduction velocity of the bilateral lower extremities. On 9-14-2015, the original utilization review non-certified a request for electromyography and nerve conduction velocity of the bilateral lower extremities.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**EMG/NCV of bilateral lower extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guideline (ODG), Treatment Index, 11th Edition (web), 2014, Low Back (updated 07/17/2015).

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

**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.