Case Number:	CM15-0193415		
Date Assigned:	10/07/2015	**Date of Injury:**	08/28/2009
Decision Date:	11/13/2015	**UR Denial Date:**	09/16/2015
Priority:	Standard	**Application Received:**	09/30/2015

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, Indiana, New York
Certification(s)/Specialty: Internal Medicine

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 is a 56 year old male who sustained an industrial injury on 8-28-2009. A review of the medical records indicates that the injured worker is undergoing treatment for lumbar spine strain with left radiculitis, left L2-3, L4-5 herniated nucleus pulposus (HNP), left knee strain, crush injury left foot and left ankle strain. According to the progress report dated 6-26-2015, the injured worker complained of constant lumbar spine pain rated 6 out of 10 with radiculopathy of the left lower extremity to the foot. There was positive numbness and tingling left leg. The physician noted "MRI LS + 3mm L4-5 L2-3." The injured worker complained of constant left knee pain rated 7 out of 10 and left foot-ankle pain rated 7 out of 10. He was noted to have increased pain since the last exam. Per the treating physician (6-26-2015), the injured worker was temporarily totally disabled. The physical exam (6-26-2015) revealed difficulty rising from sitting. Gait was antalgic. Treatment has included chiropractic treatment, physical therapy, acupuncture and medication. The treatment plan (6-26-2015) was for electromyography (EMG)-nerve conduction velocity (NCV) to evaluation radiculopathy versus neuropathy. The original Utilization Review (UR) (9-16-2015) denied requests for electromyography (EMG) and nerve conduction velocity (NCV) 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 bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC) Low Back Procedure Summary Online Version last updated 7/17/2015, Electromyography (EMG).

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back section, EMG/NCV.

Decision rationale: Pursuant to the ACOEM and Official Disability Guidelines, bilateral lower extremity EMG studies are not medically necessary. Nerve conduction studies are not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. EMGs may be useful to obtain unequivocal evidence of radiculopathy, after one month conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious. The ACOEM states unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging if symptoms persist. In this case, the injured worker's working diagnoses are L/S strain with left radiculitis; left L2-L3 and L4-L5 HNP; left knee strain status post A/S; crush injury left foot; and left ankle strain. Date of injury is August 28, 2009. Request for authorization is September 9, 2015. According to an August 26, 2015 progress note, subjective complaints include lumbar spine pain 6/10 with radiation to the left lower extremity. There is numbness and tingling. There are no right lower extremity symptoms. The injured worker received chiropractic treatment times 12, physical therapy times 13 and acupuncture times six. The treating provider is requesting EMG/NCV studies to rule out radiculopathy versus neuropathy. Objectively, injured worker has an antalgic gait. There is no physical examination of the lumbar spine. There is no neurologic evaluation of the lower extremities and lumbar spine. There is no objective evidence of radiculopathy. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. There were no unequivocal findings that identify specific nerve compromise on the neurologic evaluation. Based on the clinical information in the medical record, peer-reviewed evidence-based guidelines, no physical examination with a lumbar spine and neurologic evaluation, no subjective complaints or objective physical findings involving the right lower extremity and no unequivocal findings that identify specific nerve compromise on the neurologic evaluation, bilateral lower extremity EMG studies are not medically necessary.

Nerve Conduction Study bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC) Low Back Procedure Summary Online Version last updated 7/17/2015.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back section, EMG/NCV.

Decision rationale: Pursuant to the ACOEM and Official Disability Guidelines, bilateral lower extremity NCV studies are not medically necessary. Nerve conduction studies are not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. EMGs may be useful to obtain unequivocal evidence of radiculopathy, after one month conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious. The ACOEM states unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging if symptoms persist. In this case, the injured worker's working diagnoses are L/S strain with left radiculitis; left L2-L3 and L4-L5 HNP; left knee strain status post A/S; crush injury left foot; and left ankle strain. Date of injury is August 28, 2009. Request for authorization is September 9, 2015. According to an August 26, 2015 progress note, subjective complaints include lumbar spine pain 6/10 with radiation to the left lower extremity. There is numbness and tingling. There are no right lower extremity symptoms. The injured worker received chiropractic treatment times 12, physical therapy times 13 and acupuncture times six. The treating provider is requesting EMG/NCV studies to rule out radiculopathy versus neuropathy. Objectively, injured worker has an antalgic gait. There is no physical examination of the lumbar spine. There is no neurologic evaluation of the lower extremities and lumbar spine. There is no objective evidence of radiculopathy. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. There were no unequivocal findings that identify specific nerve compromise on the neurologic evaluation. Based on the clinical information in the medical record, peer-reviewed evidence-based guidelines, no physical examination with a lumbar spine and neurologic evaluation, no subjective complaints or objective physical findings involving the right lower extremity and no unequivocal findings that identify specific nerve compromise on the neurologic evaluation, bilateral lower extremity NCV studies are not medically necessary.