

<b>Case Number:</b>	CM15-0203276		
<b>Date Assigned:</b>	10/20/2015	<b>Date of Injury:</b>	10/21/2014
<b>Decision Date:</b>	12/02/2015	<b>UR Denial Date:</b>	10/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/15/2015

### 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

### 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 45 year old individual who sustained an industrial injury on 10-21-2014. A review of medical records indicates the injured worker is being treated for cervical sprain strain, possible cervical facet syndrome, and lumbosacral strain. Medical records dated 9-28-2015 noted neck and back pain. Physical examination noted mid and low back was non-tender. On the prior exam, reflexes patellar right +1, left +2 and Achilles nonreactive bilaterally. MRI of the lumbar spine dated 9-23-2015 revealed T12 vertebral body wedge compression deformity with expansile lesion which raises the possibility of a pathologic fracture, however, there is no edema suggesting that it could be long standing. Treatment has included six sessions of physical therapy. Utilization review form noncertified EMG-NCS for right and left lumbosacral.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**EMG/NCS for Right and Left Lumbosacral:** Overturned

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

**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 Lumbar & Thoracic (Acute & Chronic) chapter under EMGsLow Back Lumbar & Thoracic (Acute & Chronic) chapter, under Nerve conduction studies.

**Decision rationale:** The 45 year old patient complains of neck and low back pain along with numbness and tingling in arms and legs, as per progress report dated 09/28/15. The request is for EMG/NCS FOR RIGHT AND LEFT LUMBOSACRAL. There is no RFA for this case, and the patient's date of injury is 10/21/14. Diagnoses, as per progress report dated 09/28/15, included cervical sprain/strain, possible cervical facet syndrome, r/o bilateral carpal tunnel syndrome vs cervical radiculopathy, lumbosacral strain with L5-S1 small disc protrusion and facet arthropathy with left facet cyst, r/o bilateral lumbosacral radiculopathy, T12 compression fracture, and symptoms of depression and stress. Medications included Nabumetone and Nortriptyline. The patient is not working, as per progress report dated 07/20/15. ACOEM, chapter 12, page 303, Low Back Complaints states that EMG is supported by ACOEM for low back pain. NCV is not supported unless the patient has peripheral symptoms with suspicion for peripheral neuropathy. ODG Guidelines, chapter Low Back-Lumbar & Thoracic (Acute & Chronic) chapter under EMGs (electromyography) states the following: 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. ODG Guidelines, chapter 'Low Back - Lumbar & Thoracic (Acute & Chronic)' and topic 'Nerve conduction studies (NCS)', states that NCV 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. (Utah, 2006) This systematic review and meta-analysis demonstrate that neurological testing procedures have limited overall diagnostic accuracy in detecting disc herniation with suspected radiculopathy." In this case, a request for EMG/NCV of bilateral lower extremities is noted in progress report dated 09/28/15. The treater states that the study will help rule out lumbosacral radiculopathy as the patient has decreased patellar reflex on the right and tingling from left leg to knee. The request appears reasonable as it can help with accurate diagnosis and future care. ACOEM also supports use of electrodiagnostic studies to rule out radiculopathy. Hence, the request IS medically necessary.