

<b>Case Number:</b>	CM15-0203491		
<b>Date Assigned:</b>	10/20/2015	<b>Date of Injury:</b>	07/31/2014
<b>Decision Date:</b>	12/01/2015	<b>UR Denial Date:</b>	10/08/2015
<b>Priority:</b>	Standard	<b>Application</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: 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:

This is a 51-year-old male with a date of industrial injury 7-31-2014. The medical records indicated the injured worker (IW) was treated for facet syndrome, degenerative disc disease at L4-5 and continued back pain. In the progress notes (9-29-15), the IW reported low back pain and intermittent mild posterior thigh pain and numbness. On 9-3-15, the pain was described as located in the low back with right leg radicular pain. On examination (9-29-15 notes), there was pain to palpation over the bilateral L3-4 through L5-S1 facet joints and palpable paraspinal muscle spasms. Flexion was 50% of normal and extension was 10% of normal due to facet pain. Motor strength was 5 out of 5 proximally and distally, bilaterally. Sensation to light touch was intact in the bilateral lower extremities. Deep tendon reflexes were 2+ and equal bilaterally at the knees and ankles. Straight leg raise was negative bilaterally in extension at 90 degrees. Babinski and clonus were absent. FABER was negative bilaterally and the sacroiliac joints were non-tender. Treatments included physical therapy, activity modification and pain medications (not listed). The provider reviewed the MRI of the lumbar spine (9-2-15): "presence of disc degeneration at L4-5 with discogenic changes, disc desiccation and minor disc bulge. There is significant facet arthropathy at L4-5 and L5-S1". There were no previous electrodiagnostic studies submitted. The IW was temporarily totally disabled. The provider planned medial branch nerve blocks and electrodiagnostic testing to determine the presence of radiculopathy. A Request for Authorization was received for electromyography and nerve conduction velocity testing of the bilateral lower extremities. The Utilization Review on 10-8-15 non-certified the request for electromyography and nerve conduction velocity testing 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 bilateral lower extremities:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Low Back Disorders, Official Disability Guidelines, Low Back.

**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.