

<b>Case Number:</b>	CM15-0203547		
<b>Date Assigned:</b>	10/20/2015	<b>Date of Injury:</b>	01/23/2015
<b>Decision Date:</b>	12/01/2015	<b>UR Denial Date:</b>	09/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/16/2015

### 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:

The injured worker is a 44 year old female, who sustained an industrial injury on 1-23-15. The documentation on 9-3-15 noted that the injured worker has complaints of constant severe dull, sharp, stabbing, throbbing, burning low back pain, stiffness, heaviness, numbness, tingling, weakness and cramping. Lumbar spine had no bruising, swelling, atrophy or lesion present and straight leg raise is negative. The documentation on 8-24-15 noted that the lumbar spine range of motion was decreased and painful and there was tenderness to palpation of the coccyx, L3-L5 spinous processes, left S1 (sacroiliac) joint and right S1 (sacroiliac) joint and straight leg raise was positive bilaterally. The documentation on 7-27-15 noted that the injured worker had complaints of constant pain in her lower back area with frequent radiation of pain over the right lower limb. The injured worker rates her pain at its worst 8 out of 10 and a 1 to 10 scale. The documentation noted that the injured worker undergone physical therapy and then was given one epidural steroid injection on 6-19-15 which according the injured worker did not help and that her back pain and tingling and numbness sensation over the right lower lib started getting worse. Lumbar spine magnetic resonance imaging (MRI) on 3-6-15 revealed degenerative facet joint arthritis at L3-L4, L4-L5 and L5-S1 (sacroiliac), degenerative bulging disc 2 millimeter at L3- L4, 3 millimeter at L4-L5 and 5 millimeter at L5-S1 (sacroiliac). The diagnoses have included thoracic or lumbosacral neuritis or radiculitis unspecified and sprain of lumbar. Treatment to date has included gabapentin for nerve pain; zolpidem for sleep difficulties; alprazolam for anxiety; pantoprazole to protect the stomach and cyclobenzaprine to relax the muscles. The original utilization review (9-16-15) non-certified the request for electromyography and nerve conduction velocity studies 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:** Decision based on MTUS Low Back Complaints 2004, Section(s): Summary. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment for Workers' Compensation, Online Edition, 2015 Low Back - Lumbar & Thoracic (acute & chronic) Chapter.

**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/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 thoracic/lumbosacral neuritis/radiculitis unspecified; and lumbar sprain strain. The date of injury is January 23, 2015. Request for authorization is August 24, 2015. According to a chiropractic first provider's report dated June 29, 2015, the injured worker's subjective complaints included low back pain radiating to the right leg. There was neck pain. Pain score was 8/10. Objectively, lumbar spine range of motion was decreased 20%. There was tenderness to palpation at the L2 to L5 spinous processes. There is no neurologic evaluation/examination in the medical record. There is no neurology or neurologic consultation in the medical record. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Based on clinical information in the medical record, peer-reviewed evidence-based guidelines, guideline non-recommendations with minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy, no neurologic examination and no neurology consultation, bilateral lower extremity EMG/NCV studies are not medically necessary.