

Case Number:	CM15-0205579		
Date Assigned:	10/22/2015	Date of Injury:	08/28/2012
Decision Date:	12/11/2015	UR Denial Date:	10/01/2015
Priority:	Standard	Application Received:	10/20/2015

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: Arizona, Texas
 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 52 year old male, who sustained an industrial-work injury on 8-28-12. A review of the medical records indicates that the injured worker is undergoing treatment for lumbar spine Herniated Nucleus Pulposus (HNP) disc bulge with right leg symptoms. Treatment to date has included pain medication, physical therapy with no improvement, epidural steroid injection (ESI) and trigger point injections (4-21-15, 8-4-15), back brace and other modalities. The electromyography (EMG) - nerve conduction velocity studies (NCV) of the bilateral upper extremities dated 2-5-14 revealed right C6 radiculitis. Medical records dated (6-10-15 to 7-16-15) indicate that the injured worker complains of neck, mid back and low back pain that is worse and radiates to the bilateral hips and legs with numbness. The pain is rated 5-6 out of 10 on the pain scale. Per the treating physician report dated 7-16-15 the injured worker has returned to work. The physical exam dated 7-16-15 reveals tenderness to palpation and spasm in the lumbar paraspinal muscles. There is positive straight leg raise bilaterally in sitting position and there is decreased lumbar range of motion. There is decreased sensation to light touch at L4 distribution. The physician indicates he recommends electromyography (EMG) nerve conduction velocity studies (NCV) of the bilateral lower extremities (BLE) for paresthesia. The request for authorization date was 9-1-15 and requested included Electromyography (EMG) and nerve conduction velocity (NCV) of bilateral lower extremities. The original Utilization review dated 10-1-15 non-certified the request for Electromyography (EMG) and nerve conduction velocity (NCV) of bilateral lower extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electromyography (EMG) and nerve conduction velocity (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 Guidelines (ODG), Treatment Index, 13th Edition (Web), 2015, Low back - Nerve conduction studies (NSC).

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

Decision rationale: According to the MTUS, nerve conduction study (NCS) techniques permit stimulation and recording of electrical activity from individual peripheral nerves with sufficient accuracy, reproducibility, and standardization to determine normal values, characterize abnormal findings, and correlate neurophysiologic-pathologic features. These clinical studies are used to diagnose focal and generalized disorders of peripheral nerves, aid in the differentiation of primary nerve and muscle disorders (although NCS itself evaluates nerve and not muscle), classify peripheral nerve conduction abnormalities due to axonal degeneration, demyelination, and conduction block and prognosticate regarding clinical course and efficacy of treatment. NCS should not be performed or interpreted as an isolated diagnostic study. Instead, it should be performed and interpreted at the same time as an EMG. When definitive neurologic findings on physical exam, electrodiagnostic studies, lab tests, or bone scans are present imaging may be warranted. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography (EMG), and nerve conduction velocities (NCV), may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. In this case the patient has findings on physical exam consistent with a neuropathy, further testing with EMG/NCS is not medically necessary.