Case Number:	CM15-0028484		
Date Assigned:	02/20/2015	**Date of Injury:**	02/17/2000
Decision Date:	04/06/2015	**UR Denial Date:**	01/28/2015
Priority:	Standard	**Application Received:**	02/17/2015

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: 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 57 year old male, who sustained an industrial injury on 2/17/2000. The current diagnoses are post laminectomy syndrome, lumbar radiculopathy, lumbar spondylosis, and myofascial pain syndrome. Currently, the injured worker complains of back pain that radiates down both legs into his feet with associated numbness and tingling. The pain is described as an achy-type sensation in his back and legs. The pain is rated 9/10 in the right leg and 10/10 in the left. Current medications are Soma, Oxymorphone, OxyContin, and Neurontin. The physical examination of the lumbar spine revealed pain in all planes with range of motion, weakness of the left psoas, diminished sensation with numbness in both L4, L5, and S1 dermatomes, and absent deep tendon reflexes bilaterally in the patellar and gastrocnemius tendons. Treatment to date has included medications, physical therapy, chiropractic, acupuncture, several epidural steroid injections, spinal cord stimulator, and surgery. The treating physician is requesting bilateral lower extremity EMG/NCV, which is now under review. On 1/28/2015, Utilization Review had non-certified a request for bilateral lower extremity EMG/NCV. The California MTUS ACOEM Medical Treatment Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral lower Extremity EMG/NCV (Electromygram/Nerve Conductive Velocity):
Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305, 308-309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Electrodiagnostic testing (EMG/NCS). American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) http://www.aanem.org/getmedia/6513fe50-8b94-4d12-b6a9-249aca7cdb92/Recommended_Policy_EDX_Medicine_062810.pdf.aspx.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses electrodiagnostic studies. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 12 Low Back Complaints indicates that EMG may be used to clarify nerve root dysfunction. Electromyography (EMG) may be useful to identify subtle focal neurologic dysfunction. Official Disability Guidelines (ODG) Pain (Chronic) indicates that electrodiagnostic testing (EMG/NCS) are recommended depending on indications. Electromyography (EMG) and Nerve Conduction Studies (NCS) are generally accepted, well-established and widely used for localizing the source of the neurological symptoms. American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) indicates that electrodiagnostic medicine (EDX) studies can provide information to identify normal and abnormal nerve, muscle, motor or sensory neuron, and neuromuscular junction functioning. The orthopaedic spine consultation dated January 2, 2015 documented a history of posterior lumbar fusion in March 2001, followed by revision of fusion posteriorly for the hardware in October 2005. A third surgery was the anterior and posterior fusion with in 2008, and spinal stimulator in 2012. There is a history bilateral fibula fixation for fractures along with subsequent hardware removal. Neurologic deficit noted on the left side lower extremity more than right side with right side tibialis anterior 4+/5, left side tibialis anterior 4/5, EHL extensor hallucis longus 4/5. The patient cannot perform heel or toe walking due to the weakness and numbness in his feet. Motor examination reveals weakness of the left psoas 4+/5, right psoas 5/5, bilateral quadriceps 5/5, bilateral hamstrings 5/5, bilateral anterior tibialis, EHL extensor hallucis longus, gastrocnemius are noted to be 4+/5. Diminished sensation with numbness in both L4, L5 and SI dermatomes was noted. Deep tendon reflexes are absent in both patellar and gastrocnemius tendons. Physical examination demonstrated neurologic deficits. ACOEM, ODG, and AANEM clinical practice guidelines support the request for EMG electromyography and NCV nerve conduction velocity studies. Therefore, the request for EMG/NCV of the bilateral lower extremities is medically necessary.