

<b>Case Number:</b>	CM15-0058998		
<b>Date Assigned:</b>	04/03/2015	<b>Date of Injury:</b>	04/21/2014
<b>Decision Date:</b>	05/11/2015	<b>UR Denial Date:</b>	03/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/27/2015

### 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 51 year old female, who sustained an industrial injury on 4/21/2014. Diagnoses include lumbar disc herniation L5-S1 with bilateral L5-S1 radiculopathy, lumbar disc displacement without myelopathy, sciatica, positive urine screen, therapeutic drug monitor, long term use meds nec, pain psychogenic nec, and pain in joint shoulder status post left shoulder arthroscopy (2008), Treatment to date has included diagnostics including magnetic resonance imaging (MRI), epidural steroid injections, modified duty, physical therapy, acupuncture and medications. Per the Primary Treating Physician's Progress Report dated 3/04/2015, the injured worker reported low back and bilateral local anesthesia pain, numbness and tingling. Physical examination revealed spasm and guarding at the base of the lumbar spine. She can flex to around 50 degrees and extend to around 20 degrees. Straight leg raise is positive bilaterally at around 50 degrees. Sciatic notch tenderness is present bilaterally. The plan of care included injections, possible surgical intervention and electrodiagnostic studies. Authorization was requested for EMG (electromyography) 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 (electromyography) of Bilateral Lower Extremities:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Low Back - Lumbar & Thoracic (Acute & Chronic)chapter, EMGs (electromyography)Low Back - Lumbar & Thoracic (Acute & Chronic)chapter, Nerve conduction studies (NCS).

**Decision rationale:** The patient presents with low back pain radiating to lower extremities. The request is for EMG (ELECTROMYOGRAPHY) OF BILATERAL LOWER EXTREMITIES. The request for authorization is dated 04/10/15. MRI of the lumbar spine, 02/13/15, shows L5-S1: 7mm left paracentral subligamentous herniation, significant disc height loss, and moderately severe narrowing of the left neural foraminal outlet and the distortion of the exiting left L5 nerve root. Physical examination reveals spasm and guarding at the base of the lumbar spine. Range of motion is decreased. Straight leg raise is positive bilaterally. The patient has had 12 visits of physical therapy and 6 visits of acupuncture, with no improvement. She states at this time, her medications keep her at a level where she is barely able to tolerate her activities of daily living. Patient's medications include Hydrocodone-Acetaminophen, Tizanidine, Baclofen, Methadone, Hydrochlorothiazide, Glucophage and Simvastatin. Per progress report dated, 04/03/15, the patient is on modified work.ODG Guidelines, chapter 'Low Back - Lumbar & Thoracic (Acute & Chronic)' and topic 'EMGs (electromyography)', state that EMG studies are "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."Per progress report dated, 04/08/15, treater's reason for the request is "to further define the extent of the radiculopathy. Although, we do know that she has radiculopathy at specific levels, we do not know the severity. EMG would help us to distinguish between muscle conditions in which the problem begins in the muscle and muscle weakness due to nerve disorders." However, ODG guidelines indicate EMG's are not necessary if radiculopathy is already clinically obvious. Per progress report dated, 03/04/15, physical examination reveals straight leg raising is positive bilaterally. Additionally, MRI of the lumbar spine, 02/13/15, shows L5-S1: 7mm left paracentral subligamentous herniation, significant disc height loss, and moderately severe narrowing of the left neural foraminal outlet and the distortion of the exiting left L5 nerve root, corroborating radiculopathy. Furthermore, patient's diagnosis includes, lumbar disc herniation, L5-S1, with bilaterally L5-S1 radiculopathy. Therefore, the request IS NOT medically necessary.