

<b>Case Number:</b>	CM14-0116109		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	01/23/1998
<b>Decision Date:</b>	10/16/2014	<b>UR Denial Date:</b>	06/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/23/2014

### 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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 61-year-old female who reported a date of injury of 01/23/1998. The mechanism of injury was reported as a fall. The injured worker had diagnoses of cervical sprain/strain with myofasciitis, thoracic spine sprain/strain with myofasciitis, and lumbar spine sprain/strain with myofasciitis. Prior treatments included physical therapy. The injured worker had an x-ray of the left knee on 02/28/2014, with unofficial findings of bone on bone end stage osteoarthritis, with no remaining joint space, and noted bone spurs to the medial tibial region. An MRI of the lumbar spine on 03/08/2014 with an official report indicates multilevel degenerative discogenic, mild central stenosis at L3-4 and minimal at L4-5, and multilevel foraminal narrowing. Surgeries included left knee arthroscopy in 1998 and left total knee arthroplasty on 05/08/2014. The injured worker had complaints of pin in the neck, back, knees bilaterally, hips bilaterally, and right ankle, with the pain rated at 4/10 to 9/10. The clinical note dated 08/19/2014 noted the injured worker had tenderness to palpation and spasms of the trapezius, positive straight leg raise bilaterally, limited flexion of the left knee greater than 90 degrees, and joint pain with tenderness of the right knee. Medications included gabapentin. The treatment plan included the physician's recommendation for the injured worker to continue the use of Gabapentin and acupuncture 2 times a week for 4 weeks. The rationale was not indicated within the medical records provided. The Request for Authorization was received on 06/23/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Electromyography/Nerve Conduction Velocity (EMG / NCV) bilateral lower extremity:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 60-61.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Electrodiagnostic studies (EDS)

**Decision rationale:** The request for EMG / NCV Bilateral lower extremity is not medically necessary. The injured worker had complaints of pain in the neck, back, knees bilaterally, hips bilaterally, and right ankle, with the pain rated at 4/10 to 9/10. The California MTUS/ACOEM Guidelines indicate electromyography, if unequivocal objective findings that identify specific nerve compromise on the neurologic examination, is 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. Indiscriminate imaging will result in false positive findings, such as disc 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. Electromyography, including H reflex test, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than 3 to 4 weeks. Electromyography is most suited for detection of disc protrusion. The Official Disability Guidelines state nerve conduction studies (NCV) are not recommended for low back conditions. Nerve conduction studies are not recommended, and EMGs are recommended in some cases, so generally, they would not both be covered in a report for a low back condition. There is a lack of documentation the injured worker has significant nerve compromise on the neurological examination. Furthermore, the injured worker is noted to have chronic low back symptoms that have lasted more than 3 to 4 weeks for which guidelines would recommend electromyography. However, the Official Disability Guidelines do not recommend nerve conduction studies for low back symptoms, the request as submitted was for an EMG/NCV. As such, the request is not medically necessary.