

<b>Case Number:</b>	CM14-0122906		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	07/16/2010
<b>Decision Date:</b>	11/05/2014	<b>UR Denial Date:</b>	07/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/04/2014

### 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 Internal 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 (IW) sustained an injury after being punched in the back. This occurred on July 16, 2010. According to the Request for Medical Treatment Request Authorization Initial Evaluation dated May 7, 2014, the IW had no numbness or tingling in toes. There was weakness and difficulty standing on the right leg, which was due to both pain and numbness. There was back pain that was worse with cough, sneezing, and bending. There was difficulty walking on heels and toes. The IW had pain, which radiated into the right leg. The treatment plan included discogram and CT scan from L3-S1. According to the progress report dated May 12, 2014, the objective findings were unchanged. The IW was diagnosed with back pain, contusion on the back, and herniated nucleus pulposus of the lumbar with myelopathy. Diagnostic imaging and other therapies: The IW had a CT scan and blood tests (undated). The results of the examinations were absent from the medical clinical records. A prior EMG/NCV study was done in 2010 was normal and there were no new clinical findings or a change in physical examination to the present. The provider requested the current EMG/NCV to be repeated prior to a possible surgery. Magnetic resonance imaging (MRI) scan reviewed on May 7, 2014 documented narrowing of the sub-articular recess at L4-5 due to central disc protrusion. X-rays dated May 7, 2014 documented satisfactory sagittal and coronal alignment. Flexion and extension views documented no instability. There was degeneration of the L3-4, L4-5, and L5-S1 disc levels.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**EMG (Electromyography) for left lower extremity: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Electrodiagnostic studies

**Decision rationale:** Pursuant to the ACOG guidelines, low back complaints, as referenced by the California, MTUS guidelines, special studies and diagnostic and treatment considerations state electromyography (EMG) may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than 3 to 4 weeks. Pursuant to Official Disability Guidelines EMGs may be useful to obtain unequivocal evidence of radiculopathy, after one month of conservative therapy, EMGs are not necessary if radiculopathy is already clinically obvious. EMGs may be required by the AMA guidelines for impairment rating radiculopathy. In this case, the injured worker had complaints of weakness and difficulty standing on the right lower extremity because of pain and numbness. He had difficulty walking on heels and toes; however the remainder of the physical examination was unremarkable. There were no objective clinical signs present. There was no indication of specific neurologic dysfunction including no reflex, sensory or motor changes. Prior EMG/NCV was performed in 2010. Those tests were normal and there was no listing of clinical changes or clinical findings on examination from that point in time until the present. There is insufficient information in the medical record to establish medical necessity. Based on the clinical information in the peer-reviewed, evidence-based guidelines, the EMG (Electromyography) for left lower extremity is not medically necessary and appropriate.

**NCV (Nerve Conduction Velocity) for left lower extremity:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Electrodiagnostic Studies

**Decision rationale:** Pursuant to official disability guidelines network induction velocity studies are not recommended. There is minimal justification for performing nerve conduction studies when the patient is presumed to have symptoms on the basis of radiculopathy. Systematic review and meta-analysis demonstrated that neurologic testing procedures (EMG and NCV) have limited overall diagnostic accuracy in detecting disk herniation with suspected radiculopathy. EMG/NCV studies often have low combined sensitivity and specificity in confirming injury, and there is limited evidence to support the use of often uncomfortable and costly EMGs and NCV. Based on clinical information in the medical record in the peer-reviewed evidence-based guidelines the nerve conduction velocity studies are not medically necessary. In this case, the injured worker had complaints of weakness and difficulty standing on the right lower extremity because of pain and numbness. He had difficulty walking on heels and toes; however the

remainder of the physical examination was unremarkable. There were no objective clinical signs present. There was no indication of specific neurologic dysfunction including no reflex, sensory or motor changes. Prior EMG/NCV was performed in 2010. Those tests were normal and there was no listing of clinical changes or clinical findings on examination from that point in time until the present. There is insufficient information in the medical record to establish medical necessity. Based on the clinical information in the peer-reviewed, evidence-based guidelines, the NCV (Nerve Conduction Velocity) for left lower extremity is not medically necessary and appropriate.

**NCV (Nerve Conduction Velocity) of right lower extremity: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Electrodiagnostic Studies

**Decision rationale:** Pursuant to official disability guidelines network induction velocity studies are not recommended. There is minimal justification for performing nerve conduction studies when the patient is presumed to have symptoms on the basis of radiculopathy. Systematic review and meta-analysis demonstrated that neurologic testing procedures (EMG and NCV) have limited overall diagnostic accuracy in detecting disk herniation with suspected radiculopathy. EMG/NCV studies often have low combined sensitivity and specificity in confirming injury, and there is limited evidence to support the use of often uncomfortable and costly EMGs and NCV. Based on clinical information in the medical record in the peer-reviewed evidence-based guidelines the nerve conduction velocity studies are not medically necessary. In this case, the injured worker had complaints of weakness and difficulty standing on the right lower extremity because of pain and numbness. He had difficulty walking on heels and toes; however the remainder of the physical examination was unremarkable. There were no objective clinical signs present. There was no indication of specific neurologic dysfunction including no reflex, sensory or motor changes. Prior EMG/NCV was performed in 2010. Those tests were normal and there was no listing of clinical changes or clinical findings on examination from that point in time until the present. There is insufficient information in the medical record to establish medical necessity. Based on the clinical information in the peer-reviewed, evidence-based guidelines, the NCV (Nerve Conduction Velocity) of right lower extremity is not medically necessary and appropriate.

**EMG (Electromyography) of right lower extremity: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Electrodiagnostic studies

**Decision rationale:** Pursuant to the ACOG guidelines, low back complaints, as referenced by the California, MTUS guidelines, special studies and diagnostic and treatment considerations state electromyography (EMG) may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than 3 to 4 weeks. Pursuant to official disability guidelines EMGs may be useful to obtain unequivocal evidence of radiculopathy, after one month of conservative therapy, EMGs are not necessary if radiculopathy is already clinically obvious. EMGs may be required by the AMA guidelines for impairment rating radiculopathy. In this case, the injured worker had complaints of weakness and difficulty standing on the right lower extremity because of pain and numbness. He had difficulty walking on heels and toes; however the remainder of the physical examination was unremarkable. There were no objective clinical signs present. There was no indication of specific neurologic dysfunction including no reflex, sensory or motor changes. Prior EMG/NCV was performed in 2010. Those tests were normal and there was no listing of clinical changes or clinical findings on examination from that point in time until the present. There is insufficient information in the medical record to establish medical necessity. Based on the clinical information in the peer-reviewed, evidence-based guidelines, the EMG (Electromyography) of right lower extremity is not medically necessary and appropriate.