Case Number:	CM14-0127838		
Date Assigned:	09/16/2014	**Date of Injury:**	12/20/2011
Decision Date:	10/16/2014	**UR Denial Date:**	08/11/2014
Priority:	Standard	**Application Received:**	08/11/2014

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 Occupational 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 patient is a 46-year-old female who has submitted a claim for thoracic or lumbosacral neuritis or radiculitis, unspecified associated with an industrial injury date of December 20, 2011. Medical records from 2014 were reviewed, which showed that the patient complained of low back pain that radiates to the left thigh, left leg and left foot. Examination revealed a positive straight leg raise, diminished strength over the medial calf and lateral calf on the left, 3/5 strength of the left knee flexors and extensors and 4/5 strength of the left EHL. MRI of the lumbar spine dated February 13, 2012 revealed L4-L5 extrusion with effacement of the subarticular gutter. A more recent MRI (according to the UR) failed to show any progression or evidence of a surgical lesion. EMG NCV dated December 5, 2012 was normal. Treatment to date has included medications, chiropractic therapy, acupuncture, physical therapy and epidural steroid injections. Utilization review from August 11, 2014 denied the request for EMG Bilateral Lower Extremities and NCV of Bilateral Lower Extremities because a prior EMG testing revealed normal results and a recent MRI showed no progression or evidence of a surgical lesion.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG Bilateral Lower Extremities: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back Lumbar & Thoracic (Acute & Chronic) Chapter EMG (Electromyography)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain, Electrodiagnostic testing

Decision rationale: According to page 303 of CA MTUS ACOEM Low Back Chapter, the guidelines support the use of electromyography (EMG) to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three to four weeks. According to the ODG, electromyography (EMG) and Nerve Conduction Studies (NCS) are generally accepted, well established and widely used for localizing the source of the neurological symptoms and establishing the diagnosis of focal nerve entrapments. In this case, the patient presented with back symptoms and neurologic abnormalities in the physical examination. Patient complained of low back pain radiating to the left leg, corroborated by weakness and positive straight leg raise test. In 2012, the patient had normal EMG studies. It is not known whether the patient already had the back symptoms and neurologic abnormalities in 2012. However, MRI done recently showed no progression or presence of a surgical lesion compared to an MRI done in 2012. There is no clear indication to do repeat testing at this time. Moreover, signs and symptoms of radiculopathy are localized at the left lower extremity; there is no clear indication for contralateral leg EMG testing. Therefore, the request for EMG Bilateral Lower Extremities is not medically necessary.

NCV of Bilateral Lower Extremities: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back Lumbar & Thoracic (Acute & Chronic) Chapter Nerve Conduction Studies (NCS)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Nerve Conduction Studies 2014 Other Medical Treatment Guideline or Medical Evidence: Nerve Conduction Studies in Polyneuropathy: Practical Physiology and Patterns of Abnormality, Acta Neurol Belg 2006 Jun; 106 (2): 73-81

Decision rationale: The CA MTUS does not specifically address nerve conduction studies (NCS). Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, and the Official Disability Guidelines (ODG) was used instead. According to ODG, NCS of the lower extremities are not recommended if radiculopathy has already been clearly identified by EMG and obvious clinical signs. A published study entitled, "Nerve Conduction Studies in Polyneuropathy", cited that NCS is an essential part of the work-up of peripheral neuropathies. Many neuropathic syndromes can be suspected on clinical grounds, but optimal use of nerve conduction study techniques allows diagnostic classification and is therefore crucial to understanding and separation of neuropathies. In this case, the patient presented with back symptoms and neurologic abnormalities in the physical examination. Patient complained of low back pain radiating to the left leg, corroborated by weakness and positive straight leg raise test. Clinical manifestations are not consistent with peripheral neuropathy to warrant NCV. In 2012, the patient had normal EMG

studies. It is not known whether the patient already had the back symptoms and neurologic abnormalities in 2012. However, MRI done recently showed no progression or presence of a surgical lesion compared to an MRI done in 2012. There is no clear indication to do repeat electrodiagnostic testing at this time. Moreover, there are no signs and symptoms pertaining to the right lower leg to warrant NCV testing. Therefore, the request for NCV of Bilateral Lower Extremities is not medically necessary.