

Case Number:	CM14-0158081		
Date Assigned:	10/23/2014	Date of Injury:	07/26/2010
Decision Date:	01/09/2015	UR Denial Date:	08/28/2014
Priority:	Standard	Application Received:	09/26/2014

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 Emergency Medicine and is licensed to practice in New York. 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 61-year-old male who was injured on July 26, 2010. The patient continued to experience pain in low back and right knee. Physical examination was notable for tenderness to the lumbosacral spine, lumbosacral spasm, decreased range of motion, positive straight leg raise at 60 degrees, tenderness to the right knee at the medical joint line, and decreased range of motion of the right knee. Diagnoses included lumbar herniated nucleus pulposus, myoligamentous injury of the right knee, myospasm, and lumbar radiculopathy. Treatment included steroid injections, acupuncture, aqua therapy, surgery, and medications. Requests for authorization for functional capacity evaluation, chiropractic treatment of the right knee # 12, physical therapy to right knee and low back #12, interferential unit for 6 months rental, compound medication Ketoprofen/cyclobenzaprine/Lidocaine 120 gm, Theramine #90, Apprim #180, Sentra PM # 60, Mirtazapine 5 mg #30, pantoprazole, 20 mg #30, x-ray of the lumbar spine, x-ray of the right knee, MRI of the lumbar spine, MRI of the right knee, and EMG/NCV of the bilateral lower extremities were submitted for consideration.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional Capacity Evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, Chapter 7, pgs. 132-139

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty: Functional Capacity Evaluations

Decision rationale: Both job-specific and comprehensive FCEs can be valuable tools in clinical decision-making for the injured worker; however, FCE is an extremely complex and multifaceted process. Little is known about the reliability and validity of these tests and more research is needed. Guidelines for performing an FCE: If a worker is actively participating in determining the suitability of a particular job, the FCE is more likely to be successful. A FCE is not as effective when the referral is less collaborative and more directive. It is important to provide as much detail as possible about the potential job to the assessor. Job specific FCEs are more helpful than general assessments. The report should be accessible to all the return to work participants. Consider an FCE if 1. Case management is hampered by complex issues such as, prior unsuccessful RTW attempts, conflicting medical reporting on precautions and/or fitness for modified job and injuries that require detailed exploration of a worker's abilities. 2. Timing is appropriate. Close or at MMI/all key medical reports secured and additional/secondary conditions clarified. Do not proceed with an FCE if the sole purpose is to determine a worker's effort or compliance or the worker has returned to work and an ergonomic assessment has not been arranged. In this case there is no documentation that the patient is experiencing any of the conditions for FCE as listed above. In addition there is no documentation that the patient is at or close to maximal medical improvement. Therefore the request is not medically necessary.

Chiropractic treatment for the right knee, 3 x 4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58-60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions Page(s): 58.

Decision rationale: Manual therapy and evaluation are recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. Recommended treatment parameters are as follows: Time to produce effect - 4-6 treatments, frequency of 1-2 times per week with maximum duration of 8 weeks. The requested number of visits surpasses the 4-6 visits recommended to produce effect. Therefore the request is not medically necessary.

Physiotherapy for the right knee and low back, 3 x 4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions Page(s): 98-99.

Decision rationale: Chronic Pain Medical Treatment Guidelines state that there is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/cold applications, massage, diathermy, TENS units, ultrasound, laser treatment, or biofeedback. They can provide short-term relief during the early phases of treatment. Active treatment is associated with better outcomes and can be managed as a home exercise program with supervision. ODG states that physical therapy is more effective in short-term follow up. Patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy). When treatment duration and/or number of visits exceed the guideline, exceptional factors should be noted. Recommended number of visits for myalgia and myositis is 9-10 visits over 8 weeks; and for neuralgia, neuritis, and radiculitis is 8-10 visits over 4 weeks. In this case the requested 12 visits surpasses the maximum number of six recommended for clinical trial. Therefore the request is not medically necessary.

Interferential Unit, 6 months rental: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions Page(s): 118-119.

Decision rationale: Interferential current stimulation (ICS) is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. ICS is indicated when pain is ineffectively controlled due to diminished effectiveness of medications, pain is ineffectively controlled with medications due to side effects, there is a history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment, or the pain is unresponsive to conservative measures. The device should be used for a one-month trial period initially to determine if there will be functional improvement. In this case the documentation in the medical record does not support that any of the indications are present. In addition the requested duration of treatment surpasses the recommended one-month trial. Therefore the request is not medically necessary.

Compound medication: Ketoprofen / Cyclobenzaprine / Lidocaine 10% / 3% / 5%, 120mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions Page(s): 111-112.

Decision rationale: This medication is a compounded topical analgesic containing Ketoprofen, cyclobenzaprine, and Lidocaine. Topical analgesics are recommended for neuropathic pain when anticonvulsants and antidepressants have failed. Compounded topical analgesics are commonly prescribed and there is little to no research to support the use of these compounds. Furthermore, the guidelines state that "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." Ketoprofen is not currently FDA approved for a topical application. It has an extremely high incidence of photo contact dermatitis. Absorption of the drug depends on the base it is delivered in. Topical treatment can result in blood concentrations and systemic effect comparable to those from oral forms, and caution should be used for patients at risk, including those with renal failure. It is not recommended. Cyclobenzaprine is a muscle relaxant. There is no evidence for use of this muscle relaxant as a topical product. It is not recommended. Lidocaine is recommended for localized peripheral pain after the evidence of a trial for first-line therapy, such as an antidepressant or antiepileptic drug. It is only FDA approved for the treatment of post-herpetic neuralgia. In this case there is no documentation that the patient has failed treatment with first-line therapy. The drug is not recommended. This medication contains drugs that are not recommended. Therefore the medication cannot be recommended. Therefore the request is not medically necessary.

Theramine #90: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. 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) Pain, Theramine Medical Food

Decision rationale: Theramine is a medical food from [REDACTED], that is a proprietary blend of gamma-aminobutyric acid [GABA] and choline bitartrate, L-arginine, and L-serine. It is intended for use in the management of pain syndromes that include acute pain, chronic pain, fibromyalgia, neuropathic pain, and inflammatory pain. Medical Food is a food which is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation. GABA is indicated for epilepsy, spasticity and tardive dyskinesia. There is no documentation that any of these conditions is present in the patient. Choline is a precursor of acetylcholine. There is no known medical need for choline supplementation except for the case of long-term parenteral nutrition or for individuals with choline deficiency secondary to liver deficiency. Side effects of high-dose choline include hypotension, acute GI distress, and cholinergic side effects (such as sweating and diarrhea). There is no indication for the use of serine. Arginine is not indicated in current references for pain or inflammation. Theramine is not recommended under ODG. Therefore the request is not medically necessary.

Apptrim #180: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation www.ncbi.nlm.nih.gov

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Medical Foods

Decision rationale: Apptrim is a medical food consisting of a proprietary formula of amino acids and polyphenol ingredients in specific proportions, for the nutritional management of the metabolic processes associated with obesity, morbid obesity, and metabolic syndrome. The formulation consists of L-Glutamic Acid, Choline Bitartrate, and L-Serine. FDA defines a medical food as "a food which is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation." There are no quality studies demonstrating the benefit of medical foods in the treatment of chronic pain. Glutamic acid is used for treatment of hypochlorhydria and achlorhydria. Treatment indications include those for impaired intestinal permeability, short bowel syndrome, cancer and critical illnesses. It is generally used for digestive disorders in complementary medicine. It is not recommended. Choline is a precursor of acetylcholine. There is no known medical need for choline supplementation except for the case of long-term parenteral nutrition or for individuals with choline deficiency secondary to liver deficiency. There is inconclusive evidence that this product is indicated for an endurance aid, memory, seizures, and transient ischemic attacks. Side effects of high-dose choline include hypotension, acute GI distress, and cholinergic side effects (such as sweating and diarrhea). A fishy odor may occur with use. It is not recommended. There is no indication in Micromedex, Clinical Pharmacology, or AltMedDex for the use of serine. The ingredients in the medical food are not recommended. Therefore the request is not medically necessary.

Sentra PM #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. 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) Pain, Medical Food X Other Medical Treatment Guideline or Medical Evidence UpToDate: L-carnitine: Drug information Clinical use of ginkgo biloba

Decision rationale: Sentra PM is a medical food containing acetyl carnitine, glutamate, ginkgo biloba, 5-hydroxytryptophan and choline. It is intended for use in management of sleep disorders associated with depression. FDA defines a medical food as "a food which is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive

nutritional requirements, based on recognized scientific principles, are established by medical evaluation." There are no quality studies demonstrating the benefit of medical foods in the treatment of chronic pain. Acetylcarnitine is a precursor for carnitine. Carnitine is a dietary supplement indicated for carnitine deficiency. There is no documentation of carnitine deficiency in this case. Carnitine is not recommended. Glutamic acid (glutamate) is a supplement used for treatment of hypochlorhydria and achlorhydria. Treatment indications include those for impaired intestinal permeability, short bowel syndrome, cancer and critical illnesses. It is generally used for digestive disorders in complementary medicine. It is not recommended. 5-hydroxytryptophan is a supplement that has been found to be possibly effective in treatment of anxiety disorders, fibromyalgia, and obesity and sleep disorders. It has been found to be effective for depression. In alternative medicine it has been used for depression, anxiety, insomnia, obesity, aggressive behavior, eating disorders, fibromyalgia, chronic headaches and various pain disorders. It should be used with caution in individuals using SSRI antidepressants. This product has been linked to a contaminant that causes a condition called eosinophilia-myalgia syndrome. It is not recommended. Ginkgo biloba, more commonly known as ginkgo, has been used medicinally for over 1000 years. It has been used for the treatment of dementia, age-related memory impairment, and depression. Studies have not found it effective in dementia. There is preliminary evidence that it is useful in depression and anxiety. It is not recommended. Choline is a precursor of acetylcholine. There is no known medical need for choline supplementation except for the case of long-term parenteral nutrition or for individuals with choline deficiency secondary to liver deficiency. There is inconclusive evidence that this product is indicated for an endurance aid, memory, seizures, and transient ischemic attacks. Side effects of high-dose choline include hypotension, acute GI distress, and cholinergic side effects (such as sweating and diarrhea). A fishy odor may occur with use. It is not recommended. This medical food contains ingredients that are not recommended. It is therefore not recommended. Therefore the request is not medically necessary.

Mirtazapine 5mg, #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. 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) Pain, Insomnia treatment

Decision rationale: Mirtazapine is a sedating antidepressant. It can cause sedation, increased appetite, weight gain, dizziness, dry mouth and constipation; febrile neutropenia has occurred rarely. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. Various medications may provide short-term benefit. Insomnia treatment should be based on etiology. Most medications have only been evaluated for short term use (less than 4 weeks). Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. Sedating antidepressants are often used to treat insomnia; however, there is less evidence to support their use for insomnia. They may be an option in patients with coexisting depression. In this case there is no documentation that the patient is

suffering from depression or has failed first-line therapies insomnia. Therefore the request is not medically necessary.

Pantoprazole 20mg, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions Page(s): 68.

Decision rationale: Pantoprazole is a proton pump inhibitor (PPI). PPI's are used in the treatment of peptic ulcer disease and may be prescribed in patients who are using non-steroidal anti-inflammatory drugs and are at high risk for gastrointestinal events. Risk factors for high-risk events are age greater than 65, history of peptic ulcer, GI bleeding or perforation, concurrent use of ASA, corticosteroids, and/or an anticoagulant, or high dose/multiple NSAID (e.g., NSAID + low-dose ASA). The patient in this case was using NSAID medication, but did not have any of the risk factors for a gastrointestinal event. Therefore the request is not medically necessary.

X-ray of the Lumbar Spine: 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: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back- Lumbar & thoracic, Radiography

Decision rationale: Imaging of the lumbosacral spine is indicated in patients with unequivocal objective findings that identify specific nerve compromise on the neurologic examination 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. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. Further investigation is indicated in patients with history of tumor, infection, abdominal aneurysm, or other related serious conditions, who have positive findings on examination. X-rays are not recommended in the absence of red flags. In this case the patient does not have red flags. Therefore the request is not medically necessary.

X-Ray of the Right Knee: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee 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) Knee 7 Leg, Radiography

Decision rationale: X-rays of the knee are recommended as indicated below. In a primary care setting, if a fracture is considered, patients should have radiographs if the Ottawa criteria are met. Indications for imaging -- X-rays include acute trauma to the knee, fall or twisting injury, with one or more of following: focal tenderness, effusion, inability to bear weight, first study. Acute trauma to the knee, injury to knee 2 days ago, mechanism unknown and focal patellar tenderness, effusion, able to walk. Acute trauma to the knee, significant trauma (e.g, motor vehicle accident), suspect posterior knee dislocation. Non-traumatic knee pain, child or adolescent and non-patellofemoral symptoms and mandatory minimal initial exam. Non-traumatic knee pain, child or adult: patellofemoral (anterior) symptoms and mandatory minimal initial exam. Non-traumatic knee pain, adult: non-trauma, non-tumor, non-localized pain. -In this case the patient has not suffered from acute trauma. The patient's pain is localized and there are no patellofemoral symptoms. Medical documentation does not support the necessity for the x-ray of the right knee. Imaging of the lumbosacral spine is indicated in patients with unequivocal objective findings that identify specific nerve compromise on the neurologic examination 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. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. Further investigation is indicated in patients with history of tumor, infection, abdominal aneurysm, or other related serious conditions, who have positive findings on examination. X-rays are not recommended in the absence of red flags. In this case the patient does not have red flags. Therefore the request is not medically necessary.

MRI of the Lumbar Spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

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) Low Back - Lumbar and Thoracic MRI's

Decision rationale: Imaging of the lumbosacral spine is indicated in patients with unequivocal objective findings that identify specific nerve compromise on the neurologic examination 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. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. Further investigation is indicated in patients with history of tumor, infection, abdominal aneurysm, or other related serious conditions, who have positive findings on examination. MRI of the spine is recommended for indications below. MRI's are test of choice for patients with prior back surgery. MRI of the lumbar spine for uncomplicated low back pain, with

radiculopathy, is not recommended until after at least one month conservative therapy, sooner if severe or progressive neurologic deficit. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, and recurrent disc herniation). Indications for imaging -- Magnetic resonance imaging shows thoracic spine trauma: with neurological deficit, lumbar spine trauma: trauma, neurological deficit, lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit), uncomplicated low back pain, suspicion of cancer, infection, other "red flags", uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit. Also uncomplicated low back pain, prior lumbar surgery, uncomplicated low back pain, cauda equina syndrome, myelopathy (neurological deficit related to the spinal cord), traumatic, myelopathy, painful, myelopathy, sudden onset, myelopathy, stepwise progressive, myelopathy, slowly progressive, myelopathy, infectious disease patient and myelopathy, oncology patient. In this case there is no documentation that the patient has any neurologic deficit or red flags. There is no documentation of change in the patient's condition. Therefore the request is not medically necessary.

MRI of the Right Knee: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 334-335. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, MRI's (magnetic resonance imaging)

Decision rationale: Per MTUS MRI of the knee is indicated only for meniscus tear if surgery is being considered, ligament tears of the knee for confirmation, or patellar tendinitis if surgery is being considered. Per ODG indications for MRI of the knee are as follows acute trauma to the knee, including significant trauma (e.g, motor vehicle accident), or if suspect posterior knee dislocation or ligament or cartilage disruption, non-traumatic knee pain, child or adolescent: non-patellofemoral symptoms. Initial anteroposterior and lateral radiographs non-diagnostic (demonstrate normal findings or a joint effusion) next study if clinically indicated. If additional study is needed, non-traumatic knee pain, child or adult and patellofemoral (anterior) symptoms. Initial anteroposterior, lateral, and axial radiographs non-diagnostic (demonstrate normal findings or a joint effusion). If additional imaging is necessary and if internal derangement is suspected. Non-traumatic knee pain in adults, non-trauma, non-tumor, non-localized pain. Initial anteroposterior and lateral radiographs non-diagnostic (demonstrate normal findings or a joint effusion). If additional studies are indicated, and if internal derangement is suspected. Initial anteroposterior and lateral radiographs demonstrate evidence of internal derangement - Repeat MRIs: Post-surgical if need to assess knee cartilage repair tissue. (Routine use of MRI for follow-up of asymptomatic patients following knee arthroplasty is not recommended. In this case the documentation does not support that the patient is considering knee surgery. Therefore the request is not medically necessary.

EMG and NCV of the bilateral lower extremities: 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: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303, 310. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)



Decision rationale: EMG's (electromyography) are recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. Nerve conduction 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. This systematic review and meta-analysis demonstrate that neurological testing procedures have limited overall diagnostic accuracy in detecting disc herniation with suspected radiculopathy. In the management of spine trauma with radicular symptoms, EMG/nerve conduction studies (NCS) often have low combined sensitivity and specificity in confirming root injury, and there is limited evidence to support the use of often uncomfortable and costly EMG/NCS. In this case there is no documentation of motor or sensory deficit. There is no indication for the study. Therefore the request is not medically necessary.