

<b>Case Number:</b>	CM15-0110395		
<b>Date Assigned:</b>	06/18/2015	<b>Date of Injury:</b>	07/12/2013
<b>Decision Date:</b>	07/22/2015	<b>UR Denial Date:</b>	05/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/09/2015

### 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: New Jersey, Alabama, California  
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

### 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 63-year-old female, with a reported date of injury of 07/12/2013. The diagnoses include lumbar disc degeneration with bulging and possible internal derangement of the knee. Treatments to date have included an MRI of the lumbar spine on 06/23/2014 and 11/24/2014; x-rays of the lumbar spine; oral medications; and physical therapy. The progress report dated 05/13/2015 indicates that the injured worker stated that her back had not improved. She complained of low back pain, rated 9 out of 10 and left leg/foot pain, rated 6-7 out of 10. The physical examination showed an antalgic gait and lumbar flexion to 30 degrees. The initial orthopedic evaluation dated 04/01/2015 indicates that the injured worker was working on modified duties. She complained of low back pain, with radiation down the left leg, rated 9.5 out of 10 and right knee pain, rated 3-4 out of 10. The low back pain most recently had radiated down the right leg. She also experienced constant numbness in the left second, third, and fourth toes. She had completed physical therapy for the back and right knee. The physical examination showed spasm/guarding in the lumbar spine bilaterally, decreased lumbar range of motion, positive supine straight leg raise test with buttock and leg pain, sensory examination of the left lower extremity showed a deficit at the L5 level, normal bilateral knee range of motion, and normal bilateral hip range of motion. The previous physical therapy reports were not included in the medical records provided for review. The treating physician requested an EMG/NCV (electromyography/nerve conduction velocity) of the bilateral lower extremity and core strengthening twice a week for six weeks.

## IMR ISSUES, DECISIONS AND RATIONALES

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

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

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** According to MTUS guidelines (MTUS page 303 from ACOEM guidelines), "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." EMG has excellent ability to identify abnormalities related to disc protrusion (MTUS page 304 from ACOEM guidelines). According to MTUS guidelines, needle EMG study helps identify subtle neurological focal dysfunction in patients with neck and arm symptoms. "When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks." (page 178). EMG is indicated to clarify nerve dysfunction in case of suspected disc herniation (page 182). EMG is useful to identify physiological insult and anatomical defect in case of neck pain (page 179). Although the patient developed lower back pain, there is no clear evidence that the patient developed peripheral nerve dysfunction, root dysfunction or nerve entrapment. MTUS guidelines do not recommend EMG/NCV without signs of radiculopathy or nerve dysfunction. Therefore, the request for Electromyography (EMG)/Nerve Conduction Velocity (NCV) bilateral lower extremity (BLE) is not medically necessary.

**Core strengthening twice per week for 6 weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

**Decision rationale:** According to MTUS guidelines, Physical Medicine is "recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order

to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment." (Fritz, 2007) There is no documentation of objective findings that support musculoskeletal dysfunction requiring more physical therapy sessions. There is no documentation of the outcome of previous physical therapy sessions and home exercise. . There is no documentation supporting additional physical therapy sessions. Therefore, Core strengthening twice per week for 6 weeks is not medically necessary.