

<b>Case Number:</b>	CM15-0117109		
<b>Date Assigned:</b>	06/25/2015	<b>Date of Injury:</b>	03/08/2012
<b>Decision Date:</b>	07/27/2015	<b>UR Denial Date:</b>	06/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/17/2015

### 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: California

Certification(s)/Specialty: Preventive Medicine, Occupational 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 34 year old male who sustained an industrial injury on 3/08/2012. Diagnoses include low back and bilateral leg pain, 4mm disc bulge at L4-L5 and 4mm disc bulge at L5-S1 per magnetic resonance imaging (MRI) (1/26/2015), L4-5 degenerative disc disease and status post left sided L5-S1 microdiskectomy (9/04/2014). Comorbid conditions includes obesity (BMI 34.5). Treatment to date has included surgery, lumbar epidural steroid injections, cane, physical therapy and medications. Per the Primary Treating Physician's Progress Report dated 4/30/2015, the injured worker reported persistent pain in the lower back rated as 8/10 that is constant and about the same as the last visit. However, he complains of worsening radicular pain and numbness down the left leg. He ambulates with a slow and antalgic gait pattern and with the assistance of a cane. Physical examination of the lumbar spine revealed loss of range of motion. Straight leg raise was positive bilaterally, right greater then left with radiation of pain to the posterior thigh, anterolateral legs and dorsal feet. He has some loss of sensation in the bilateral lower extremities. The plan of care included diagnostic testing, psychiatric consultation and follow-up care. Authorization was requested for EMG (electromyography)/NCV (nerve conduction studies) bilateral lower extremities.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**EMG/NCS Bilateral Lower extremities: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation ODG Low Back (updated 4/29/15) Electrodiagnostic studies (EDS).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-4, 309.

**Decision rationale:** Electromyography (EMG) and Nerve Conduction Velocity (NCV) are diagnostic tests used to measure nerve and muscle function, and may be indicated when there is pain in the limbs, weakness from spinal nerve compression, or concern about some other neurologic injury or disorder. Criteria for their use are very specific. The EMG-NCV tests will identify physiologic and structural abnormalities that are causing nerve dysfunction. Although the literature does not support its routine use to evaluate for nerve entrapment or low back symptoms, it can identify subtle focal neurologic dysfunction in patients whose physical findings are equivocal and prolonged (over 4 weeks). When spinal cord etiologies are being considered, sensory-evoked potentials (SEPs) would better help identify the cause. While the ACOEM guidelines support use of electrodiagnostic testing for subtle signs of radicular injury it recommends against using these tests for patients with clinically obvious radiculopathies. This patient has a clinically obvious radiculopathy with signs and symptoms that are not subtle and is supported by imaging studies clearly defining anatomic lesions consistent with the patient's complaints and exam. There would be little value to obtaining electrodiagnostic studies at this time. The request is not medically necessary.