Case Number:	CM15-0119037		
Date Assigned:	06/29/2015	Date of Injury:	04/14/2015
Decision Date:	07/28/2015	UR Denial Date:	06/11/2015
Priority:	Standard	Application Received:	06/19/2015

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: Iowa, Illinois, Hawaii
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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 35 year old male, who sustained an industrial injury on 04/14/2015. Medical records provided by the treating physician did not indicate the injured worker's mechanism of injury. The injured worker was diagnosed as having right knee sprain/strain, right elbow sprain/strain, and lumbar sprain/strain with right sided radiculopathy. Treatment and diagnostic studies to date has included chiropractic therapy, magnetic resonance imaging of the lumbar spine, magnetic resonance imaging of the right knee, and a home exercise program. In a progress note 05/27/2015 dated the treating chiropractor performed a functional capacity evaluation that was revealing for overall functional improvement but with continued pain and difficulty with lifting and kneeling activities. The treating chiropractor also noted that the injured worker continues to have complaints of numbness and tingling to the lower extremities. The treating chiropractor noted that magnetic resonance imaging performed on 05/17/2015 was revealing for disc desiccation at lumbar two to three through lumbar five to sacral one, degenerative changes at lumbar five to sacral one, hemangioma at sacral one, straightening of the lumbar lordotic curvature, Schmorl's nodes at lumbar three through five, disc herniations at lumbar two to three, disc herniations at lumbar three to four with spinal canal narrowing, disc herniations at lumbar four to five with hypertrophy of the bilateral facets, and a pseudic bulge at lumbar five to sacral one with facet hypertrophy. The treating chiropractor requested nerve conduction velocity with an electromyogram of the upper and lower extremities with the treating chiropractor noting that the injured worker continues to have numbness and tingling to the lower

extremities, but the documentation did not indicate the specific reason for the requested treatment of a nerve conduction velocity with electromyogram to the bilateral upper extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

Nerve Conduction Velocity (NCV)/ Electromyography (EMG) of upper and lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260-262, 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), EMG, NCVPain, Electrodiagnostic testing (EMG/NCS).

Decision rationale: ACOEM recommends "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". ODG further states that EMG is "Recommended as an option (needle, not surface). EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious". ACOEM States "Appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful". ODG states "Recommended needle EMG or NCS, depending on indications. Surface EMG is not recommended. 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, such as carpal tunnel syndrome or radiculopathy, which may contribute to or coexist with CRPS II (causalgia), when testing is performed by appropriately trained neurologists or physical medicine and rehabilitation physicians (improperly performed testing by other providers often gives inconclusive results). As CRPS II occurs after partial injury to a nerve, the diagnosis of the initial nerve injury can be made by electrodiagnostic studies". ODG further clarifies "NCS is not recommended, but EMG is 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". The treating physician does not document evidence of radiculopathy in the upper extremities, muscle atrophy or abnormal neurologic findings. The treating physician has not met the above ACOEM and ODG criteria for an EMG. As such the request for Nerve Conduction Velocity (NCV)/ Electromyography (EMG) of upper and lower extremities is not medically necessary.