

<b>Case Number:</b>	CM15-0177764		
<b>Date Assigned:</b>	09/18/2015	<b>Date of Injury:</b>	10/12/2007
<b>Decision Date:</b>	10/22/2015	<b>UR Denial Date:</b>	08/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/09/2015

### 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: 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 56 year old female who sustained an industrial injury on 10-12-2007. According to the most recent progress report submitted for review and dated 07-23-2015, the injured worker reported persistent low back and right leg pain. Pain was intermittent and located in the center of the right buttocks. Pain was described as aching, burning pressure and sharp. Associated symptoms included tingling. There was referral of pain down to leg with some tingling in the right foot. Current pain level was rated 5 on a scale of 1-10. Pain at its worst was rated 8 and 3 at its best. Activities and movement worsened pain. MRI of the lumbar spine performed in 2009 showed diffuse disc bulges at lumbar 4-5 and L5-S1 impinging bilateral nerve roots at both 4-5 and L5-S1. No significant spinal stenosis was noted. Lower limb strength exam demonstrated 5 out of 5 bilateral hip flexion, knee extension, ankle dorsiflexion and great toe extension except nothing. Sensation examination demonstrated grossly intact to light touch in bilateral lower limbs except nothing. Reflexes were 1 to 2 plus and symmetric bilateral patella and Achilles except nothing. Upper motor neuron signs clonus negative bilateral was noted. Lordosis was normal. Tenderness was primarily in the right lower lumbar paraspinals. Right oblique extension with pain was noted. Lumbar spinous processes Spring test with back pain was noted. Right buttock pain with Slump test was noted. Right buttock pain with supine leg raise was noted. Diagnoses included degeneration of lumbar intervertebral disc, lumbar foraminal stenosis and type II or unspecified diabetes mellitus without mention of complication not stated as controlled. The provider noted that the injured worker's presentation suggested a diagnosis of right lumbar radiculopathy. Known foraminal stenosis in 2009 on MRI was noted.

On exam, positive dural stretch tests in lumbar 5 distribution, tender to palpation right lower lumbar paraspinals was noted. The treatment plan included MRI lumbar spine without contrast. She was to follow up in 4 weeks to review MRI. A progress report dated 08-06-2015 noted that MRI was denied because no physiologic evidence of nerve injury. "They commented no electrodiagnostic testing done." "EMG testing ordered to evaluate for chronic radiculopathy changes." An authorization request dated 08-06-2015 was submitted for review. The requested services included electromyography and nerve conduction velocity studies. On 08-14-2015, Utilization Review non-certified the request for electromyogram of the left lower extremity, modified the request for nerve conduction velocity of the left lower extremity and certified the request for electromyogram for the right lower extremity and nerve conduction velocity of the right lower extremity.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Electromyogram (EMG) of the left lower extremity: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Knee Complaints 2004, and Ankle and Foot Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

**Decision rationale:** Per the MTUS Guidelines, EMG may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. In this case, although an MRI dated 11/2009 revealed a disc bulge at L4-5 and L5-S1 with impingement of bilateral nerve roots at both levels, the patient only complains of symptoms on the right side. There is also no objective clinical findings on the left, therefore, the request for electromyogram (EMG) of the left lower extremity is not medically necessary.

#### **Nerve conduction velocity (NCV) of the left lower extremity: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Knee Complaints 2004, and Ankle and Foot Complaints 2004.

**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 (NCS) Section.

**Decision rationale:** The MTUS Guidelines do not specifically address nerve conduction studies of the lower extremities. Per the ODG, nerve conduction studies are not recommended because there is minimal justification of performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. In this case, although an MRI dated 11/2009 revealed a disc bulge at L4-5 and L5-S1 with impingement of bilateral nerve roots at both levels, the patient only complains of symptoms on the right side. There is also no objective clinical findings on the left, therefore, the request for nerve conduction velocity (NCV) of the left lower extremity is not medically necessary.