

<b>Case Number:</b>	CM15-0095986		
<b>Date Assigned:</b>	05/22/2015	<b>Date of Injury:</b>	11/19/2014
<b>Decision Date:</b>	06/24/2015	<b>UR Denial Date:</b>	05/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/19/2015

### 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: North Carolina  
 Certification(s)/Specialty: Family Practice

### 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 44 year old male, who sustained an industrial injury on 11/19/14. He has reported initial complaints of left foot and ankle and low back injury after a slip and fall at work. The diagnoses have included lumbosacral sprain/strain, left ankle/foot strain, myofascial pain syndrome and history of hypertension, hypercholesterolemia and sleep apnea. Treatment to date has included medications, diagnostics, and activity modifications, left Achilles rupture repair 9 years ago, sleep apnea surgery, pain management, physical therapy and home exercise program (HEP). Currently, as per the physician progress note dated 3/23/15, the injured worker complains of low back pain that radiates to the bilateral hips and down the right leg and to the knees as well. He reports a numbness and tingling sensation in the distal lower extremities. He also reports a 30 pound weight gain over time. The physical exam reveals lumbosacral spine range of motion is 50 percent of normal, tenderness to palpation in the lower lumbar area, iliolumbar and sacroiliac regions. The buttocks and greater trochanters are moderately tender bilaterally, there are mild spasms in the low back and facet maneuver is equivocal bilaterally. The lower extremity exam reveals straight leg raise elicits back pain. There is tenderness in the posterior heel cord area of the left heel on exam in the area of the previous surgery. There are areas of irregularity on palpation and a hardened nodule is noted near the proximal region of tenderness in the left ankle. It is unclear if this is a remnant of the prior tendon allograft or something else. There is tenderness to palpation in this area and the anterior ankle is non tender. The diagnostic testing that was performed included Magnetic Resonance Imaging (MRI) of the lumbar spine dated 12/19/14 reveals mild bilateral facet hypertrophy, mild bilateral neural foraminal narrowing, disc

bulge and ligamentum flavum hypertrophy. There was x-rays of the ankle and low back done in the past also but no results were noted in the records. The current medications included Norco and Flexeril. The physician requested treatment included electromyography (EMG) /nerve conduction velocity studies (NCV) of the 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 of the Bilateral Lower Extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Electrodiagnostic testing.

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

**Decision rationale:** The ACOEM chapters on low back complaints and the need for lower extremity EMG/NCV states: Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients 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. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures). 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. There are unequivocal objective findings of nerve compromise on the neurologic exam provided for review. However there is not mention of surgical consideration. There are no unclear neurologic findings on exam. For these reasons, criteria for lower extremity EMG/NCV have not been met as set forth in the ACOEM. Therefore the request is not medically necessary.