Case Number:	CM15-0098285		
Date Assigned:	05/29/2015	**Date of Injury:**	06/19/2002
Decision Date:	07/02/2015	**UR Denial Date:**	05/04/2015
Priority:	Standard	**Application Received:**	05/21/2015

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 51 year old male, who sustained an industrial injury on 6/19/2002. The current diagnoses are status post lumbar fusion from L2 through L5, residual neuritis of the lower legs, and chronic C7 radiculopathy. According to the progress report dated 4/22/2015, the injured worker complains of numbness and tingling in his bilateral lower legs to the level of his feet. He has had these symptoms since surgery. Additionally, he reports neck discomfort, tightness, and referred pain. He has numbness and tingling to his long/index finder of bilateral hands. The level of pain is not rated. The physical examination reveals tenderness to palpation at the lumbosacral junction, painful and restricted range of motion, numbness in the soles of his feet, and tightness with straight leg raise on the left. The current medications are Hydrocodone. Treatment to date has included medication management, x-rays, MRI studies, physical/aquatic therapy, pre-operative electrodiagnostic testing, and surgical intervention. The plan of care includes EMG/NCS of the bilateral upper and lower extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electromyogram (EMG)/Nerve conduction study (NCS) of the bilateral upper and lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 178, 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic (Pain): Electrodiagnostic testing (EMG/NCS).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 177-179, 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back Chapter/Nerve Conduction Studies (NCS) SectionLow Back Chapter/Nerve Conduction Studies (NCS) Section.

Decision rationale: The MTUS Guidelines address the use of NCS in detection of neurological abnormalities at the elbow and wrist, but for the use cervical radiculopathy it recommends the use of EMG and NCV to help identify subtle focal neurological dysfunction in patients with neck or arm symptoms lasting more than three or four weeks. The ODG does not recommend the use of NCS to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but recommended if the EMG is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic process if other diagnoses may be likely based on the clinical exam. There is minimal justification for performing NCS when a patient is already presumed to have symptoms on the basis of radiculopathy. While cervical electrodiagnositic studies are not necessary to demonstrate a cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality, diabetic neuropathy, or some problem other than a cervical radiculopathy, with caution that these studies can result in unnecessary over treatment. The injured worker had an EMG of the upper extremity in 2012 that revealed C7 radiculopathy bilaterally. 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. 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. The injured worker has subjective and objective signs of continued post-surgical numbness in the lower extremities that would warrant the need for an EMG/NCV. This request is for EMG/NCV of both the upper and lower extremities. The EMG/NCV is not warranted, therefore, the request for Electromyogram (EMG)/Nerve conduction study (NCS) of the bilateral upper and lower extremities is determined to not be medically necessary.