

<b>Case Number:</b>	CM14-0151602		
<b>Date Assigned:</b>	09/19/2014	<b>Date of Injury:</b>	07/19/2013
<b>Decision Date:</b>	11/05/2014	<b>UR Denial Date:</b>	08/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/17/2014

### 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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 40-year-old female who reported an injury on 07/19/2013. The injured worker's treatment history included medications, cervical MRI studies, functional capacity evaluation, lumbar MRI studies, and thoracic MRI studies. The injured worker had undergone a cervical MRI on 08/05/2014 that revealed straightening of the normal cervical lordosis, which may be secondary to the injured worker's positioning or muscle spasm. Disc desiccation with 1 mm to 2 mm diffuse disc bulges noted at C4-5 and C5-6 levels without cervical spinal cord or nerve root compression. MRI of the lumbar spine done on 08/05/2014 revealed decreased disc height with disc desiccation noted. A 2 mm diffuse disc bulge was identified. The bulging disc abuts, but does not compress the ventral aspect of the thecal sac. There was associated mild narrowing of the L5 neural foramina bilaterally. MRI of the thoracic spine done on 08/05/2014 revealed disc desiccation with a 3 mm left sided disc protrusion noted at the T8-9 level, which does not abut the thoracic spinal cord. It may abut does not compress the left ventral nerve root at this level. The injured worker was evaluated on 08/12/2014 and it was documented the injured worker complained of having pain over the left side of her body, from the neck to her elbow, mid back, low back, and left thigh that was described as aching. She experiences intermittent numbness and weakness in the left upper and lower extremities. The pain was worse with sitting, standing, walking, bending, lifting, and lying down. The pain was better with medications. She rated the pain a 9/10 to 10/10 on the pain scale without medications, and 7/10 to 8/10 with medications. She denied any symptoms or neurological changes. The physical examination of the cervical and thoracic spine revealed the injured worker had 5/5 left upper extremity strength and 5/5 right upper extremity strength. Sensation was intact and equal. DTRs are +1 and symmetric. Spurling's sign was negative. There was no clonus or increased tone. Hoffmann's sign was negative bilaterally. There was tenderness over the cervical and thoracic

paraspinals on the left. There was tenderness over the facet joints on the left. Cervical spine range of motion was reduced in all planes. There was tenderness over her left chest near the axilla. The diagnoses included lumbar back pain, possible lumbar radiculitis, neck pain, lumbar discogenic pain, cervical discogenic pain, possible cervical facet pain, left shoulder pain, myofascial pain, thoracic pain, thoracic discogenic pain, and chronic pain syndrome. The Request for Authorization dated 08/15/2014 was for EMG/NCV studies 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 (Electromyography) of the bilateral lower extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** ACOEM state electromyography is recommended in cases of peripheral nerve impingement. If no improvement or worsening has occurred within 4 to 6 weeks, electrical studies may be indicated. The Guidelines further state that an EMG may be useful to obtain unequivocal evidence of radiculopathy and after 1 month consider conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious. The medical records report pain only in the left leg. Furthermore, with straight leg raising only on the left, with positive left straight leg raising and decreased sensation over the lateral left leg, reasonable to make a diagnosis of left L4 and L5 radiculopathy without an EMG. As such, the request for EMG (Electromyography) of the bilateral lower extremities is not medically necessary and appropriate.

**NCV (Nerve Conduction Velocity) of the bilateral lower extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), NCV of the lower extremities. Low Back, NCV.

**Decision rationale:** The Official Disability guidelines state that an NCV is not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. There is a lack of documentation indicating positive provocative testing indicating pathology to the lumbar that revealed lack of functional deficits. There is no indication of failure of conservative care treatment to include physical therapy and medication management. Furthermore, the guidelines do not recommend NCV for lower extremity. The submitted medical records report pain only in the left leg with

straight leg raising only on the left. Furthermore, with positive left straight leg raising and decreased sensation over the lateral left leg, it is reasonable to make a diagnosis of left L4 and L5 radiculopathy without an EMG/NCV study. As such, the request for NCV (Nerve Conduction Velocity) of the bilateral lower extremities is not medically necessary and appropriate.