

<b>Case Number:</b>	CM14-0173282		
<b>Date Assigned:</b>	10/24/2014	<b>Date of Injury:</b>	05/05/2014
<b>Decision Date:</b>	11/25/2014	<b>UR Denial Date:</b>	10/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/20/2014

### 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 Internal Medicine 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 41-year-old man who sustained an industrial related injury on May 5, 2014 while removing a pipe with a large wrench. He was unable to loosen the pipe, so he decided to use another piece of pipe to lay over the wrench and push forcefully. As he did so, he felt something pop in his back with an onset of moderate pain. The injured worker attended 7 physical therapy sessions from June 3, 2014 to July 1, 2014 without significant improvement. Pursuant to the September 128, 2014 progress note, the injured worker presented with complaints of back pain. Physical examination revealed slow gait in a guarded manner. Sitting caused pain in the lower back. There was thoracic spine tenderness to palpation, and spasms bilaterally in the upper/mid/lower thoracic region. There was decreased thoracic spine range of motion, lumbar spine tenderness to palpation in the spinal processes at L1-L3. Straight leg raise was positive, right 45 degrees, and left 25 degrees. There was decreased deep tendon reflexes, left ankle at 1+/2, decreased motor strength left lower extremity at 4/5, decreased sensation in the left anterolateral thigh, anterior knee, medial left and foot, lateral thigh, anterolateral leg, mid-dorsal foot, posterior leg and lateral foot. The injured worker was diagnosed with sprain/strain, thoracic region; and sacral sprain/strain. Treatment plan includes: Continue medications as directed. A list of current medications was not documented in the medical record.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Electromyography/Nerve Conduction Velocity (EMG/NCV) Bilateral Lower Extremities:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, EMG (Electromyography)/Nerve Conduction Studies

**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, Electromyography/Nerve Conduction Velocity (EMG/NCV).

**Decision rationale:** Pursuant to the Official Disability Guidelines, nerve conduction velocity studies and EMGs are not medically necessary. The guidelines recommend as an option (needle, not surface). EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after one month of conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious. Regarding nerve conduction studies for the lower extremities, the ODG state NCV are "not recommended." There is minimal justification for performing nerve conduction studies when the patient is presumed to have symptoms on the basis of radiculopathy. The ACOEM states "electrodiagnostic studies are indicated where a Computed Tomography (CT) scan or MRI is equivocal and their ongoing pain complaints that raise the question of whether there may be a neurological compromise that may be identifiable (lower extremity symptoms consistent with radiculopathy, spinal stenosis, peripheral neuropathy." In this case, the injured worker is a 41-year-old man. He has complaints of back pain. Physical examination was notable for thoracic spine tenderness palpation and spasm bilateral upper mid-lower thoracic region. There was lumbar spine tenderness to palpation spinal processes L1-L3, bilateral paraspinal muscles, bilateral sacroiliac joints and spasm bilateral paraspinal muscles. Straight leg raising was positive motor strength was decreased left lower extremity 4/5. The documentation does not indicate radiculopathy. There were no positive physical findings to support radiculopathy. Consequently, NCV/EMGs are not medically necessary. Based on clinical information in the medical record and the peer-reviewed evidence-based guidelines, EMG/nerve conduction studies are not medically necessary.