

Case Number:	CM13-0005600		
Date Assigned:	12/11/2013	Date of Injury:	03/15/1999
Decision Date:	04/28/2014	UR Denial Date:	07/09/2013
Priority:	Standard	Application Received:	08/01/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a Physician Reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The Physician Reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Neuromuscular Medicine, and is licensed to practice in Maryland. 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 Physician 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 patient is a 58 year old male and has a work injury dated 3/15/99. The patient continues to experience right shoulder, thoracic spine, lumbar spine, bilateral hip and right knee pain. The diagnoses include: status post right knee arthroscopy, July 30, 2008; prior arthroscopic meniscectomy, right knee, August 2002; status post bilateral hip arthroplasties, September 2003 on the right and October 2002 on the left; posttraumatic lumbar sprain/strain; mild to moderate chronic right L5 radiculopathy; mild left L5 radiculopathy; mild right L4 and S1 radiculopathy; status post right shoulder arthroscopy with labral repair and subacromial decompression, January 12, 2011. The treatment for the lumbar spine has included physical therapy, lumbar rhizotomy, and medication management. There is discussion that patient is a lumbar fusion candidate. There is a request for the medical necessity of nerve conduction studies on the left lower extremity and nerve conduction studies on the right lower extremity. The EMG portion of the test was certified on both legs on prior utilization review. An 11/14/13 thoracic MRI revealed multiple areas of disc degeneration and bone changes. There is also a small thin area of syringohydromyelia seen within the thoracic spinal cord beginning at the level of the T7-T5 level extending to the level of the T9-T10 intervertebral disc. A lumbar MRI dated 7/18/13 revealed: 1) There is a broad-based posterior central disc protrusion at L 1-2 level; 2) There is mild disc bulge at L2-3 level with a focal left foraminal disc extrusion result in moderate left neural foramen narrowing and impingement of the left L2 nerve root; 3) There is disc bulge at L3-4 and L5-S1 levels resulting in bilateral neural foramen narrowing level resulting in lateral neural foramen narrowing; 4) There is a grade 1 spondylolisthesis at L4-5 level resulting in lateral neural foramen narrowing. A 7/18/13 electrodiagnostic study reveals evidence of mild to moderate chronic L5 radiculopathy and mild L4, S1 radiculopathy on the right side. The

electrodiagnostic study reveals evidence of mild L5 radiculopathy on the left side. Nerve conduction studies demonstrate no evidence for peripheral neuropathy or evidence for abnormalities from nerve root impingement. A 6/24/13 orthopedic examination reveals that the patient states his low back feels worse and currently complains of constant moderate pain worse on the right side of his low back radiating down to the hip and occasionally down the anterior aspect of his right leg. He notes tingling of both upper thighs. He has constant moderate mid back pain, stiffness and pressure between his shoulder blades. He complains of intermittent moderate and occasionally severe bilateral hip pain. He notes an occasional vibrating sensation of the hips. He complains of intermittent moderate and occasionally severe right knee pain with popping. He denies giving way, locking, and/or swelling at this time. Physical exam findings reveal on this visit that there is decreased lumbar range of motion. A straight leg raise test is positive bilaterally with pain radiating down the posterior of the legs, right greater than left. There is also right hip pain elicited. Gross motor strength of the quadriceps, extensor hallucis longus, ankle inversions, ankle eversion is 5/5 bilaterally. Hip flexion is 4/5 on the right and 5/5 on the left. Dermatome assessment is unremarkable.

IMR ISSUES, DECISIONS AND RATIONALES

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

NCV, RIGHT LOWER EXTREMITY: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Table12-8.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM), 421 First Avenue, SW, Suite 300 East, Rochester, Minnesota 55902, USA. Muscle Nerve 33: 436-439, 2006.

Decision rationale: A NCV (nerve conduction velocity) study of the right lower extremity is medically necessary and appropriate according to the MTUS and AANEM guidelines. A prior UR did not approve the nerve conduction study but did approve the needle EMG. The ACOEM low back chapter states that 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. H-reflexes are considered part of the nerve conduction study and therefore a nerve conduction study of the right lower extremity is medically appropriate. Additionally the 2006 AANEM position statement titled Proper performance and interpretation of electrodiagnostic studies in the issue of Muscle Nerve 33: pages 436 - 439 states that except in unique situations, nerve conduction studies and needle EMG should be performed together in a study design determined by a trained neuromuscular physician. There are additional etiologies besides peripheral polyneuropathy and radicular that can cause lower extremity symptoms in a patient such as entrapment/compression neuropathies or plexopathies. The documentation reveals that the electromyographer was evaluating radiculopathy vs distal compression neuropathy. This is appropriate according to the AANEM guidelines. The request for NCV right lower extremity is medically necessary and appropriate.

NCV, LEFT LOWER EXTREMITY: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Table 12-8.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation American Association of Neuromuscular & Electrodiagnostic Medicine, 421 First Avenue SW, Suite 300 East, Rochester, Minnesota 55902, USA. Muscle Nerve 33:436-439, 2006

Decision rationale: A NCV (nerve conduction velocity) study of the left lower extremity is medically necessary and appropriate according to the MTUS and AANEM guidelines. A prior UR did not approve the nerve conduction study but did approve the needle EMG. The ACOEM low back chapter states that 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. H-reflexes are considered part of the nerve conduction study and therefore a nerve conduction study of the right lower extremity is medically appropriate. Additionally the 2006 AANEM position statement titled Proper performance and interpretation of electrodiagnostic studies in the issue of Muscle Nerve 33: pages 436 - 439 states that except in unique situations, nerve conduction studies and needle EMG should be performed together in a study design determined by a trained neuromuscular physician. There are additional etiologies besides peripheral polyneuropathy and radicular that can cause lower extremity symptoms in a patient such as entrapment/compression neuropathies or plexopathies. The documentation reveals that the electromyographer was evaluating radiculopathy vs distal compression neuropathy. This is appropriate according to the AANEM guidelines. The request for NCV left lower extremity is medically necessary and appropriate.