Case Number:	CM13-0019131		
Date Assigned:	10/11/2013	**Date of Injury:**	11/03/2005
Decision Date:	01/06/2014	**UR Denial Date:**	08/13/2013
Priority:	Standard	**Application Received:**	09/03/2013

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 and Rehabilitation has a subspecialty in Sports Medicine and is licensed to practice in Maryland, New York and Texas. 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 52-year-old male who reported an injury on 05/01/2003. The patient underwent electrodiagnostic studies that concluded there was chronic left S1 radiculopathy and axonal polyneuropathy with left meralgia paresthetica. The patient underwent an MRI that revealed a disc protrusion at the L3-4 with bilateral nerve root compromise and bilateral facet arthropathy, a disc protrusion at the L4-5 with bilateral nerve root compromise and bilateral facet arthropathy, and a disc protrusion at the L5 S1 with bilateral nerve root compromise. The patient continued to complain of low back pain radiating into the bilateral lower extremities. Physical findings included tenderness to the mid and distal lumbar vertebrae with pain with range of motion. It was noted that the patient had a positive seated nerve root test and dysesthesia from the L4 to S1 dermatomes with weakness of the ankles and toes. The patient's diagnoses included cervical discopathy with radiculitis and lumbar discopathy with radiculitis. The patient's treatment plan included spinal fusion of the L4 to S1 levels.

IMR ISSUES, DECISIONS AND RATIONALES

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

A somatosensory evoked potential, upper and lower limbs: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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, Electrodiagnostic Studies Section..

Decision rationale: The requested Somatosensory evoked potential for the upper and lower limbs is not medically necessary or appropriate. The patient does have a diagnosis of low back pain with radiculopathy that is confirmed by clinical findings, an electromyography study, and imaging studies. The California Medical Treatment and Utilization Schedule does not specifically address generalized electrodiagnostic study criteria. The Official Disability Guidelines (ODG) recommend electrodiagnostic studies should be medically indicated, the number of tests performed should be the minimum needed to establish an accurate diagnosis. As the patient's diagnosis has already been established with previous electrodiagnostic studies, clinical evidence, and other electrodiagnostic studies, it is unclear what an additional study would contribute to the patient's treatment plan. Therefore, the somatosensory evoked potential for the upper and lower limbs is not medically indicated. As such, the requested 1 somatosensory evoked potential, upper and lower limbs is not medically necessary or appropriate.

A two (2) needle electromypgraphy, limited study of muscles in one (1) extremity or non-limb muscles (unilateral or bilateral), other than thoracic paraspinal cranial nerve supplied muscles or sphincters: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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, Electrodiagnostic Studies Section. .

Decision rationale: The requested 2 needle electromypgraphy, limited study of muscles in 1 extremity or non-limb muscles (unilateral or bilateral), other than thoracic paraspinal cranial nerve supplied muscles or sphincters is not medically necessary or appropriate. The patient does have a diagnosis of low back pain with radiculopathy that is confirmed by clinical findings, an electromyography study, and imaging studies. The California Medical Treatment and Utilization Schedule does not specifically address generalized electrodiagnostic study criteria. The Official Disability Guidelines (ODG) recommend electrodiagnostic studies should be medically indicated, the number of tests performed should be the minimum needed to establish an accurate diagnosis. As the patient's diagnosis has already been established with previous electrodiagnostic studies, clinical evidence, and other electrodiagnostic studies, it is unclear what an additional study would contribute to the patient's treatment plan. Therefore, the 2 needle electromypgraphy, limited study of muscles in 1 extremity or non-limb muscles (unilateral or bilateral), other than thoracic paraspinal cranial nerve supplied muscles or sphincters is not medically indicated. As such, the requested 2 needle electromypgraphy, limited study of muscles in 1 extremity or non-limb muscles (unilateral or bilateral), other than thoracic paraspinal cranial nerve supplied muscles or sphincters is not medically necessary or appropriate.

Five (5) intraoperative neurophysiology testing: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Alemo, S., & Sayadipour, A. (2010). Role of intraoperative neurophysiologic monitoring in lumbosacral spine fusion and instrumentation: a retrospective study. World neurosurgery, 73(1), 72-76..

Decision rationale: The requested 5 intra-operative neurophysiology testing is not medically necessary or appropriate. Although peer-reviewed literature, "Role of intra operative neurophysiological monitoring in lumbosacral spine fusion and instrumentation, a retrospective study" does state that this type of monitoring is beneficial during spinal hardware placement, it is also stated that the best way to appropriately identify spinal hardware placement remains a postsurgical CT scan. The clinical documentation submitted for review does not provide justification of the need for this additional type of monitoring. A postoperative CT scan would sufficiently identify hardware placement. As such, the requested 5 intra-operative neurophysiology testing is not medically necessary or appropriate.