MAXIMUS Federal Services

Case Number:	CM14-0019668		
Date Assigned:	04/28/2014	Date of Injury:	12/08/2009
Decision Date:	07/08/2014	UR Denial Date:	02/11/2014
Priority:	Standard	Application Received:	02/18/2014

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 Occupational 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 patient is an employee of [redacted] and has submitted a claim for thoracic/ lumbosacral neuritis/radiculitis associated with an industrial injury date of December 8, 2009.Treatment to date has included oral and topical analgesics, muscle relaxants, lumbar brace, lumbar spine surgery, lumbar epidural steroid injection, TENS, massage therapy, heat/cold modality, home exercise program, and physical therapy.Medical records from 2012 to 2014 were reviewed and showed constant, sharp low back pain graded 8/10 and progressing right lower extremity sensory symptoms, becoming more proximal up to the level of the mid-thigh. Physical examination showed an antalgic gait favoring the left lower extremity; lumbar paraspinal muscle spasm and tenderness; symmetrical muscle strength and bulk of the bilateral lower extremity; and Deep tendon reflexes (DTRs) were 1+ and symmetrical. The sensory exam showed change in sensation to light touch, involving the right lower extremity from the mid-thigh distally. MRI of the lumbar spine obtained on December 27, 2012 revealed lumbar dextroscoliosis, mild spinal stenosis at L2-3, L3-4, L4-5 and L5-S1; mild foraminal stenosis at L2-3 and L4-5; spondylolisthesis with severe bilateral facet arthropathy, and facet hypertrophy and effusion at L4-5; and a large right-sided facet joint cyst at L4-L5. The working diagnoses are myelopathy and radiculopathy. Electromyography (EMG) and conduction velocity examination of the bilateral lower extremities were requested to evaluate the lumbar radiculopathy and compare the H-reflexes; while SEP (Somatosensory Evoked Potentials) was requested to evaluate the myelopathy. Utilization review dated February 11, 2014 modified the request for bilateral lower extremity EMG and conduction velocity to EMG of the bilateral lower extremity only, because the previous studies are not available and the symptoms have changed. The request for lower extremity SEP study was denied because there was no evidence of myelopathy on examination.

IMR ISSUES, DECISIONS AND RATIONALES

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

BILATERAL LOWER EXTREMITY CONDUCTION VELOCITY EXAMINATION: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Nerve Conduction Studies.

Decision rationale: As stated on page 298-303 of the ACOEM Low Back Guidelines referenced by CA MTUS, electrodiagnostic testing is considered a second-line test generally used to identify subtle, focal neurologic dysfunction in those individuals with lumbar radicular complaints that have eluded detection on first-line lumbar MRI. ODG states that EMG and not nerve conduction velocity (NCV) studies are not recommended as there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. In this case, the patient complains of low back pain with radiculopathy and progressing right lower extremity sensory symptoms. Since the guidelines do not recommend NCV for patients with radicular symptoms, the medical necessity has not been established. Therefore, the request for bilateral lower extremity Conduction Velocity examination is not medically necessary.

LOWER EXTREMITY SEP (SOMATOSENSORY EVOKED POTENTIALS) STUDY: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178, 182. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Evoked Potential Studies.

Decision rationale: As stated on page 172 & 182 of the ACOEM Neck and Upper Back Guidelines referenced by CA MTUS, sensory-evoked potentials (SEPs) can be performed when neurological exam is not clear and spinal stenosis or myelopathy is suspected. ODG Low Back Chapter states that evoked potential studies are recommended as a diagnostic option for unexplained myelopathy and/or in unconscious spinal cord injury patients. It is not recommended for radiculopathies and peripheral nerve lesions where standard nerve conduction velocity studies are diagnostic. In this case, the working diagnoses were myelopathy and radiculopathy. The guideline clearly state that SEPs are not recommended for radiculopathies. Moreover, there was no evidence of myelopathy based on the physical examination. The medical necessity has not been established. Therefore, the request for lower extremity SEP (Somatosensory Evoked Potentials) study is not medically necessary.