

<b>Case Number:</b>	CM14-0164152		
<b>Date Assigned:</b>	10/08/2014	<b>Date of Injury:</b>	09/09/2013
<b>Decision Date:</b>	11/10/2014	<b>UR Denial Date:</b>	09/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/06/2014

### 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 Rehabilitation & Pain Management has a subspecialty in Interventional Spine 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 a 64 year old female with an injury date of 09/09/13. Based on the 07/30/14 progress report provided by [REDACTED], the patient complains of right foot pain at the right medial ankle and right arch. Patient presents with antalgic gait. Physical examination to the right foot reveals pain and guarding, no crepitus and tenderness to medial ankle. Negative Tinel. Progress report dated 08/01/14 by [REDACTED], states patient is experiencing swelling and extreme tenderness in the ankle after being injected with Depo-Medrol. Treater states under discussion section of progress report dated 08/22/14, "right medial ankle post MCL sprain; right abductor digiti quinti atrophy, possible compression at abductor hallucis origin; possible tarsal tunnel syndrome." Based on response to injection, treater states he does not think she has an intra-articular component of her pain. Treater plans EMG/NCV to rule out tarsal tunnel syndrome. MRI of the Right Ankle 07/22/14. Findings:- insertional tendinopathy and tenosynovitis of the posterior tibialis tendon- plantar fasciitis with calcaneal enthesopathy- trace amount of fluid around the peroneus brevis and peroneus longus tendons- marked diffuse fatty atrophy of the abductor digiti minimi muscle. Diagnosis 07/30/14- sprain ankle MCL, symptomatic- joint derangement, ankle and foot, symptomatic- neuritis, lower limb, symptomatic. Diagnosis 08/01/14- right index finger tendon disruption- left ankle internal derangement. [REDACTED] is requesting EMG/NCV Bilateral Lower Extremities. The utilization review determination being challenged is dated 09/17/14. The rationale is "partial certification." [REDACTED] is the requesting provider, and he provided treatment reports from 05/02/14 - 08/29/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**EMG/NCV Bilateral Lower Extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation ODG-TWC Low Back Procedure Summary

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

**Decision rationale:** The patient presents with bilateral foot pain and antalgic gait. The request is for EMG/NCV Bilateral Lower Extremities. MRI of the Right Ankle dated 07/22/14 reveals insertional tendinopathy and tenosynovitis of the posterior tibialis tendon. Treater states under discussion section of progress report dated 08/22/14, "right ankle MCL sprain, possible impingement, right abductor digiti quinti atrophy, possible compression at abductor hallucis origin. possible tarsal tunnel syndrome." Her diagnosis dated 07/30/14 includes symptomatic lower limb neuritis. For EMG, ACOEM Guidelines page 303 states "Electromyography, including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks." ODG guidelines under foot/ankle chapter does not discuss electrodiagnostics. <http://www.ncbi.nlm.nih.gov/pubmed/16003732>, NIH states: "Usefulness of electrodiagnostic techniques in the evaluation of suspected tarsal tunnel syndrome: an evidence-based review. This evidence-based review was performed to evaluate the utility of nerve conduction studies (NCSs) and needle electromyography (EMG) in the diagnosis of tibial neuropathy at the ankle (tarsal tunnel syndrome, TTS). A total of 317 articles on TTS were identified that were published in English from 1965 through April 2002, from the National Library of Medicine MEDLINE database. The sensitivity of needle EMG abnormalities could not be determined. NCSs may be useful for confirming the diagnosis of tibial neuropathy at the ankle, recommendation Level C. Well-designed studies are needed to evaluate more definitively EDX techniques in TTS." Review of the reports do not mention back pain or radiculopathy and the request is for investigation of tarsal tunnel syndrome per 8/22/14 report. However, based on NIH, well-designed studies are needed to evaluate more definitely electrodiagnostic exam techniques in tarsal tunnel syndrome. The request is not medically necessary.