

Case Number:	CM14-0077793		
Date Assigned:	07/18/2014	Date of Injury:	08/28/2009
Decision Date:	09/29/2014	UR Denial Date:	05/09/2014
Priority:	Standard	Application Received:	05/27/2014

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 a 58-year-old female who has submitted a claim for rule out right cubital tunnel syndrome, rule out bilateral carpal tunnel syndrome, chronic low back pain, radiculitis/neuropathic pain on right lower extremity, and status post bilateral foot surgery associated with an industrial injury date of August 28, 2009. Medical records from 2013-2014 were reviewed. The patient complained of upper extremity and low back pain. The pain was associated with numbness and tingling. There was neuropathic pain in her upper extremity to the thumb and ulnar nerve distribution bilaterally and shooting pain in the lower extremities down the lateral aspect of the toes. She has had electrodiagnostic testing of the lower extremity showing radiculopathy. Physical examination showed positive Tinel's test on the right cubital tunnel. Left and right wrist examination showed positive Tinel's, Phalen's, and median nerve compression tests. Lumbar spine examination showed positive tenderness and spasm in the paralumbar musculature. Range of motion of the lumbar spine was limited with pain. The patient was unable to heel walk and walk on tiptoes secondary to foot surgery. Straight leg raise test was positive bilaterally. MRI of the lumbar spine, dated March 25, 2014, revealed scoliotic curvature of the lumbar spine, moderate central canal stenosis at L4-L5 with moderate facet arthropathy and ligamentum flavum hypertrophy, at L4-L5 there is a midline disc protrusion with abutment of the descending L5 nerve roots bilaterally, and at L5-S1 there is a midline disc protrusion with abutment of the descending S1 nerve roots bilaterally. Treatment to date has included medications, physical therapy, acupuncture, home exercise program, activity modification, MPJ steroid injections, left ankle surgery, bilateral foot surgery, and lumbar epidural steroid injections. Utilization review, dated May 9, 2014, modified the request for bilateral upper and lower extremity EMG/NCV to EMG/NCV of the bilateral upper extremities only because there

was documented exam evidence providing support for indications of nerve compromise for both upper extremities only and not the lower extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG Bilateral Upper Extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007), Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints Page(s): 537.

Decision rationale: CA MTUS ACOEM Guidelines state that electromyography (EMG) studies may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. In this case, the patient complained of numbness and tingling sensation at bilateral upper extremities, specifically the ulnar nerve distribution bilaterally. Physical examination showed positive Tinel's at the cubital tunnel, positive Phalen's, and positive median nerve compression test bilaterally. Motor strength was intact. However, clinical manifestations are not consistent with focal neurologic deficit to warrant EMG. There is no clear indication for EMG at this time. Therefore, the request for EMG of bilateral upper extremities is not medically necessary.

EMG 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 Official Disability Guidelines (ODG).

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

Decision rationale: According to page 303 of CA MTUS ACOEM Low Back Chapter, the guidelines support the use of electromyography (EMG) to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three to four weeks. In this case, patient complained of low back pain radiating to bilateral lower extremities, specifically at lateral aspect of toes. Pain was described as sharp and stabbing, associated with numbness and tingling sensation. Physical examination showed motor strength of 4/5 at bilateral hip flexors and knee extensors. Reflexes were intact. Straight leg raise test was positive bilaterally. Patient was unable to walk on toes and heels secondary to foot surgery. Clinical manifestations are consistent with focal neurologic deficit; hence, EMG may be necessary. However, MRI of the lumbar spine, dated March 25, 2014, revealed moderate central canal stenosis at L4-L5 and midline disc protrusion at L5-S1, with abutment of the descending S1 nerve roots bilaterally. There is no clear indication for EMG at this time when MRI has clearly demonstrated presence

of radiculopathy. It is undetermined how EMG results can affect treatment plans. The medical necessity cannot be established due to insufficient information. Therefore, the request for electromyography (EMG) of the bilateral lower extremities is not medically necessary.

NCV Bilateral Upper Extremities: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 261-262. Decision based on Non-MTUS Citation Official Disability Guidelines, Carpal Tunnel Syndrome, Nerve Conduction Studies Other Medical Treatment Guideline or Medical Evidence: Nerve Conduction Studies in Polyneuropathy: Practical Physiology and Patterns of Abnormality, Acta Neurol Belg 2006 Jun; 106 (2): 73-81.

Decision rationale: CA MTUS ACOEM Guidelines state that appropriate electrodiagnostic studies may help differentiate between carpal tunnel syndrome and other conditions, such as cervical radiculopathy. These include nerve conduction studies, or in more difficult cases, electromyography may be helpful. Moreover, ODG states that NCS is not recommended to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but is recommended if the EMG is not clearly consistent with radiculopathy. A published study entitled, "Nerve Conduction Studies in Polyneuropathy", cited that NCS is an essential part of the work-up of peripheral neuropathies. Many neuropathic syndromes can be suspected on clinical grounds, but optimal use of nerve conduction study techniques allows diagnostic classification and is therefore crucial to understanding and separation of neuropathies. In this case, the patient complained of numbness and tingling sensation at bilateral upper extremities, specifically the ulnar nerve distribution bilaterally. Physical examination showed positive Tinel's at the cubital tunnel, positive Phalen's, and positive median nerve compression test bilaterally. Motor strength was intact. Clinical manifestations are consistent with peripheral neuropathy to warrant NCV. Guideline criteria were met. Therefore, the request for NCV of bilateral upper extremities is medically necessary.

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 Official Disability Guidelines (ODG).

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, Nerve conduction studies (NCS) Other Medical Treatment Guideline or Medical Evidence: Nerve Conduction Studies in Polyneuropathy: Practical Physiology and Patterns of Abnormality, Acta Neurol Belg 2006 Jun; 106 (2): 73-81.

Decision rationale: The CA MTUS does not address NCS specifically. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines, (ODG), Low Back Chapter, Nerve Conduction Studies (NCS) was used instead. The Official Disability Guidelines state that there is minimal justification for performing nerve conduction studies when the patient is presumed to have symptoms on the basis of radiculopathy. A published study entitled, "Nerve Conduction Studies in Polyneuropathy", cited that NCS is an essential part of the work-up of peripheral neuropathies. Many neuropathic syndromes can be suspected on clinical grounds, but optimal use of nerve conduction study techniques allows diagnostic classification and is therefore crucial to understanding and separation of neuropathies. In this case, patient complained of low back pain radiating to bilateral lower extremities, specifically at lateral aspect of toes. Pain was described as sharp and stabbing, associated with numbness and tingling sensation. Physical examination showed motor strength of 4/5 at bilateral hip flexors and knee extensors. Reflexes were intact. Straight leg raise test was positive bilaterally. Patient was unable to walk on toes and heels secondary to foot surgery. Clinical manifestations are consistent with focal neurologic deficit; hence, NCV is not warranted. Moreover, MRI of the lumbar spine, dated March 25, 2014, revealed moderate central canal stenosis at L4-L5 and midline disc protrusion at L5-S1, with abutment of the descending S1 nerve roots bilaterally. There is no clear indication for NCV at this time when MRI has clearly demonstrated presence of radiculopathy. Guideline criteria were not met. Therefore, the request for NCV of the bilateral lower extremities is not medically necessary.