

Case Number:	CM14-0086170		
Date Assigned:	07/23/2014	Date of Injury:	02/12/2009
Decision Date:	09/26/2014	UR Denial Date:	05/26/2014
Priority:	Standard	Application Received:	06/09/2014

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 Medicine and Rehabilitation, 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:

This patient is a 64-year-old male with a date of injury of 02/12/2009. The listed diagnoses are: Left shoulder pain secondary to sleeping on the left hip following a hip surgery., Status post right shoulder arthroscopy., Spondylosis, lumbar spine., Disk protrusion, lumbar spine., Musculoligamentous sprain/strain, lumbar spine., and Right total hip replacement following degenerative hip. The medical file provided for review includes no progress reports from the requesting physician. According to this report, the patient presents with pain and discomfort in the lumbar spine that is described as pins and needles, and throbbing in nature. The patient also complains of constant pain in the bilateral hips described as burning, throbbing, pins and needles, and sharp in nature. The patient's bilateral hip pain radiates to both legs. There is tenderness to palpation over the lumbar spine and positive straight leg raise with pain radiating down to the bilateral thigh. This is a request for NCV (nerve conduction velocity) for the bilateral lower extremities and EMG of the bilateral lower extremity. Utilization Review denied the request on 05/26/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

NCV Nerve Conduction Velocity of the the left lower extremity: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back (updated 5/12/14) Nerve conduction studies (NCS).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG guidelines have the following regarding NCV studies: Not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. (Utah, 2006) This systematic review and meta-analysis demonstrate that neurological testing procedures have limited overall diagnostic accuracy in detecting disc herniation with suspected radiculopathy. (Al Nezari, 2013) See also the Carpal Tunnel Syndrome Chapter for more details on NCS. Studies have not shown portable nerve conduction devices to be effective. EMGs (electromyography) are recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious.

Decision rationale: This patient presents with back and hip pain that radiates to the lower extremities. The treater is requesting nerve conduction velocity for the bilateral lower extremities. The MTUS and ACOEM do not discuss NCS. However, ODG guidelines have the following regarding NCV studies: "Not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. (Utah, 2006) This systematic review and meta-analysis demonstrate that neurological testing procedures have limited overall diagnostic accuracy in detecting disc herniation with suspected radiculopathy. (Al Nezari, 2013)" In regard to NCV studies, ODG guidelines states, Nerve conduction studies (NCS) are not recommended for low back conditions. It further states, "In the management of spine trauma with radicular symptoms, EMG/nerve conduction studies (NCS) often have low combined sensitivity and specificity in confirming root injury, and there is limited evidence to support the use of often uncomfortable and costly EMG/NCS." Recommendation is for denial. Review of the medical file indicates the patient had an MRI of the lumbar spine in 2010 which documented "extensive spondylosis with modic endplate changes at levels L3 to S1 with stenosis throughout." X-ray of the lumbar spine from 04/21/2014 documented extensive multilevel lumbar spondylosis at L3 to S1 with bone to bone erosion and disk space height collapse. In this case, both MRI and x-ray confirm significant stenosis. A Nerve conduction study for further investigation is not necessary. Furthermore, EMG with H-reflex may be indicated for low back pain but not NCV studies. Recommendation is for denial.

NCV Nerve Conduction Velocity of the the right extremity: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back (updated 5/12/14) Nerve conduction studies (NCS).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG guidelines have the following regarding NCV studies: Not recommended. There is minimal justification for

performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. (Utah, 2006) This systematic review and meta-analysis demonstrate that neurological testing procedures have limited overall diagnostic accuracy in detecting disc herniation with suspected radiculopathy. (Al Nezari, 2013) See also the Carpal Tunnel Syndrome Chapter for more details on NCS. Studies have not shown portable nerve conduction devices to be effective. EMGs (electromyography) are recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious.

Decision rationale: This patient presents with back and hip pain that radiates to the lower extremities. The treater is requesting nerve conduction velocity for the bilateral lower extremities. The MTUS and ACOEM do not discuss NCS. However, ODG guidelines have the following regarding NCV studies: "Not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. (Utah, 2006) This systematic review and meta-analysis demonstrate that neurological testing procedures have limited overall diagnostic accuracy in detecting disc herniation with suspected radiculopathy. (Al Nezari, 2013)" In regard to NCV studies, ODG guidelines states, Nerve conduction studies (NCS) are not recommended for low back conditions. It further states, "In the management of spine trauma with radicular symptoms, EMG/nerve conduction studies (NCS) often have low combined sensitivity and specificity in confirming root injury, and there is limited evidence to support the use of often uncomfortable and costly EMG/NCS." Recommendation is for denial. Review of the medical file indicates the patient had an MRI of the lumbar spine in 2010 which documented "extensive spondylosis with modic endplate changes at levels L3 to S1 with stenosis throughout." X-ray of the lumbar spine from 04/21/2014 documented extensive multilevel lumbar spondylosis at L3 to S1 with bone to bone erosion and disk space height collapse. In this case, both MRI and x-ray confirm significant stenosis. A Nerve conduction study for further investigation is not necessary. Furthermore, EMG with H-reflex may be indicated for low back pain but not NCV studies. Recommendation is for denial.

Electromyography (EMG) of the left lower extremity: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back (updated 5/12/2014) EMGs (eletromyography).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG guidelines has the following regarding Electrodiagnostic Studies: See also Nerve conduction studies (NCS) which are not recommended for low back conditions, and EMGs (Electromyography) which are recommended as an option for low back. Electrodiagnostic studies should be performed by appropriately trained Physical Medicine and Rehabilitation or Neurology physicians. For more information and references, see the Carpal Tunnel Syndrome Chapter. Below are the Minimum Standards from that chapter. Minimum Standards for electrodiagnostic studies: The American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) recommends the following minimum standards:(1) EDX testing should be

medically indicated (i.e., to rule out radiculopathy, lumbar plexopathy, peripheral neuropathy).(2) Testing should be performed using EDX equipment that provides assessment of all parameters of the recorded signals. Studies performed with devices designed only for "screening purposes" rather than diagnosis are not acceptable.(3) The number of tests performed should be the minimum needed to establish an accurate diagnosis.(4) NCSs (Nerve conduction studies) should be either (a) performed directly by a physician or (b) performed by a trained individual under the direct supervision of a physician. Direct supervision means that the physician is in close physical proximity to the EDX laboratory while testing is underway, is immediately available to provide the trained individual with assistance and direction, and is responsible for selecting the appropriate NCSs to be performed.(5) EMGs (Electromyography - needle not surface) must be performed by a physician specially trained in electrodiagnostic medicine, as these tests are simultaneously performed and interpreted.(6) It is appropriate for only 1 attending physician to perform or supervise all of the components of the electrodiagnostic testing (e.g., history taking, physical evaluation, supervision and/or performance of the electrodiagnostic test, and interpretation) for a given patient and for all the testing to occur on the same date of service. If both tests are done, the reporting of NCS and EMG study results should be integrated into a unifying diagnostic impression.(7) If both tests are done, dissociation of NCS and EMG results into separate reports is inappropriate unless specifically explained by the physician. Performance and/or interpretation of NCSs separately from that of the needle EMG component of the test should clearly be the exception (e.g. when testing an acute nerve injury) rather than an established practice pattern for a given practitioner. (AANEM, 2009) Note: For low back NCS are not recommended and EMGs are recommended in some cases, so generally they would not both be covered in a report for a low back condition.ODG guidelines have the following regarding EMG studies:Recommended as an option (needle, not surface). EMGs (elec

Decision rationale: This patient presents with low back and bilateral hip pain that radiates into the lower extremities. The treater is requesting bilateral EMG of the lower extremities. ACOEM Guidelines page 303 states, "Electromyography (EMG), including H-reflex test, may be useful to identify subtle, focal neurologic dysfunction in patients with low back pain symptoms lasting more than 3 or 4 weeks." ODG Guidelines has the following regarding EMG studies, "EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy after 1 month conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious." In this case, MRI showed significant stenosis. The patient has persistent pain down the legs and an EMG study would appear reasonable to determine the extent of nerve root damage or the specific level of problem. Recommendation is for authorization.

Electromyography (EMG) of the right lower extremity: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back (updated 5/12/2014) EMGs (eletromyography).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG guidelines has the following regarding Electrodiagnostic Studies:See also Nerve

conduction studies (NCS) which are not recommended for low back conditions, and EMGs (Electromyography) which are recommended as an option for low back. Electrodiagnostic studies should be performed by appropriately trained Physical Medicine and Rehabilitation or Neurology physicians. For more information and references, see the Carpal Tunnel Syndrome Chapter. Below are the Minimum Standards from that chapter. Minimum Standards for electrodiagnostic studies: The American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) recommends the following minimum standards: (1) EDX testing should be medically indicated (i.e., to rule out radiculopathy, lumbar plexopathy, peripheral neuropathy). (2) Testing should be performed using EDX equipment that provides assessment of all parameters of the recorded signals. Studies performed with devices designed only for "screening purposes" rather than diagnosis are not acceptable. (3) The number of tests performed should be the minimum needed to establish an accurate diagnosis. (4) NCSs (Nerve conduction studies) should be either (a) performed directly by a physician or (b) performed by a trained individual under the direct supervision of a physician. Direct supervision means that the physician is in close physical proximity to the EDX laboratory while testing is underway, is immediately available to provide the trained individual with assistance and direction, and is responsible for selecting the appropriate NCSs to be performed. (5) EMGs (Electromyography - needle not surface) must be performed by a physician specially trained in electrodiagnostic medicine, as these tests are simultaneously performed and interpreted. (6) It is appropriate for only 1 attending physician to perform or supervise all of the components of the electrodiagnostic testing (e.g., history taking, physical evaluation, supervision and/or performance of the electrodiagnostic test, and interpretation) for a given patient and for all the testing to occur on the same date of service. If both tests are done, the reporting of NCS and EMG study results should be integrated into a unifying diagnostic impression. (7) If both tests are done, dissociation of NCS and EMG results into separate reports is inappropriate unless specifically explained by the physician. Performance and/or interpretation of NCSs separately from that of the needle EMG component of the test should clearly be the exception (e.g. when testing an acute nerve injury) rather than an established practice pattern for a given practitioner. (AANEM, 2009) Note: For low back NCS are not recommended and EMGs are recommended in some cases, so generally they would not both be covered in a report for a low back condition. ODG guidelines have the following regarding EMG studies: Recommended as an option (needle, not surface). EMGs (elec

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