Case Number:	CM14-0210343		
Date Assigned:	12/23/2014	Date of Injury:	06/08/2012
Decision Date:	09/24/2015	UR Denial Date:	11/14/2014
Priority:	Standard	Application Received:	12/16/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California
Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 injured worker is a 50-year-old female who sustained a work related injury June 8, 2012. Past history included status post open reduction internal fixation left ankle fracture January 2014, status post bilateral L5-S1 transforaminal epidural steroid injection June 2014, February 7, 2014. A thoracic spine x-ray, performed March 20, 2014, (report present in the medical record) revealed a mild collapse with an anterior wedge fracture of the lower thoracic vertebrae. According to a primary treating physician's progress report, dated September 25, 2014, the injured worker presented with complaints of constant low back pain, mainly on the right side, radiating to the right lower extremity with numbness, tingling, and weakness. When ambulating with a cane, pain radiates to the mid back. Objective findings included; straight leg raise remains positive on the right, and decreased range of motion. Diagnoses are thoracic spine sprain, strain; status post ankle surgery secondary to thoracic spine injury; anterior wedging with compression fracture of T12 vertebrae; clinical right lower extremity radiculopathy. Some handwritten notes are difficult to decipher. At issue, is a request for authorization for a voltage-actuated sensory nerve conduction threshold of the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltage-Actuated Sensory Nerve Conduction Threshold of Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, EMGs (electromyography), 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) Low Back - Lumbar & Thoracic (Acute and Chronic) Chapter, under Nerve Conduction Studies and Other Medical Treatment Guidelines www.aetna.com/cpb/medical/data/300_399/0357. htmll.

Decision rationale: The patient presents with low back pain, rated 6-8/10, radiating to the right lower extremity, with tingling, numbness and weakness. The request is for VOLTAGE ACTUATED SENSORY NERVE CONDUCTION THRESHOLD OF LUMBAR SPINE. Physical examination to the lumbar spine on 08/11/15 revealed tenderness to palpation over the bilateral paravertebral are of L5-S1 level. Range of motion was limited in all planes with pain. Sensory exam showed decreased sensitivity to touch along the L1-S1 dermatome in both lower extremities. Motor examination showed decreased strength in the bilateral lower extremities dermatomal level L5-S1. Straight leg raising test in the seated position was positive on the left for radicular pain at 80 degrees and on the right for radicular pain at 40 degrees. Patient's diagnosis, per 07/03/14 progress report include T/S S/S; S/P orif LT, ankle secondary to T/S injury; anterior wedging w/compression fx of T12 vertebra, and clinical rle radiculopathy. Patient is to remain off-work for 6 weeks, per 07/03/14 progress report. ODG Guidelines, Low Back - Lumbar & Thoracic (Acute and Chronic) Chapter, under Nerve Conduction Studies states: "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 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. (Charles, 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." www.aetna.com/cpb/medical/data/300_399/0357. htmll, AETNA guidelines has the following: Aetna considers quantitative sensory testing (QST), also known as pressure-specified sensory device testing, experimental and investigational for the detection of hyperalgesia in chronic pain individuals on long-term opioids, the evaluation of carpal tunnel syndrome/musculoskeletal pain, the management of individuals with neuropathy, prediction of the response to opioid treatment, or any other diagnoses because its diagnostic value has not been established. Treater has not provided a reason for the request. The patient continues with low back pain that radiated into the right lower extremity, to the calf area and there is no documentation that patient has had prior lumbar NCT studies. Per 07/03/14 progress report, patient is diagnosed with clinical right lower extremity radiculopathy. However, qualitative sensory testing (QST) is considered experimental and is not supported by AETNA. ODG guidelines does not support NCT studies to address radiating leg symptoms when these are presumed to be coming from the spine. There are no concerns regarding plexopathies or peripheral neuropathies to warrant NCT studies. Therefore, the request IS NOT medically necessary.