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| Case Number: | CM15-0190089 | | |
| Date Assigned: | 10/02/2015 | Date of Injury: | 09/14/2014 |
| Decision Date: | 11/09/2015 | UR Denial Date: | 09/14/2015 |
| Priority: | Standard | Application Received: | 09/28/2015 |

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: Montana

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 52 year old male heavy equipment operator, who sustained an industrial injury on 9-14-2014. The injured worker is being treated for tendinopathy of the quadriceps tendon without acute rupture left knee, mild tricompartmental osteoarthritis, status post lumbar laminectomy and hardware installation, mild diffuse lumbar spondylosis and degenerative disc disease. Treatment to date has included surgical intervention of the lumbar spine, diagnostics, modified work, physical therapy, injections to the left knee and medications. There is a history of remote lumbar fusion at L5S1 in 1986. Per the Primary Treating Physician's Progress Report dated 8-14-2015 the injured worker reported lumbar spine and left knee pain. He notes that his lumbar spine radiates to the bilateral lower extremities. He rates his pain as 8 out of 10 at rest and 10 out of 10 with activity. Objective findings included tenderness to palpation of the lumbar spine paravertebrals with decreased range of motion. There are "significant degenerative changes noted throughout the lumbar spine taken on x-rays during his initial visit." Work status was "remain off work." The plan of care included electrodiagnostic testing and authorization was requested for EMG (electromyography) and NCV (nerve conduction studies) of the right and left lower extremities. On 9-14-2015, Utilization Review non-certified the request for EMG and NCV of the right and left lower extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG and NCV of left lower extremity: Upheld

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

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Nerve Conduction Studies and Electromyography (EMG).

Decision rationale: The ODG guidelines state that Nerve Conduction Studies are 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. 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. In this case the medical records do not document complaint of pain, numbness or tingling in the lower extremities. Straight leg raising tests are described as positive however, the nature and extent of those symptoms are not described. There is no indication of any dermatomal pattern for leg symptoms. Although she has been on medications, there is no documentation of efficacy of any conservative treatment in the medical records. MRI of the lumbar spine has been requested but result is not available in the records. There is no indication of likely peripheral neuropathy in the lower extremities. The request for nerve conduction velocity of the right lower extremity is not medically necessary. The MTUS ACOEM guidelines and ODG guidelines note that electromyography (EMG), including H- reflex test, may be useful to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than 3-4 weeks. The ODT guidelines note that electrodiagnostic testing is used to rule out radiculopathy, lumbar plexopathy or peripheral neuropathy. EMGs are recommended as an option (needle, not surface). EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. In this case the medical records do document complaint of low back pain, with pain, motor and sensory deficits in dermatomal patterns in the bilateral lower extremities. Straight leg raising tests are described as positive. The EMG and NCV studies are requested to obtain unequivocal documentation of radiculopathy and help to determine future treatment options, including possible surgery. The MTUS and ODG guidelines clearly state that NCVs are not recommended. EMG however, may be useful to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than 3-4 weeks. A request for EMG of the left lower extremity would be consistent with the guidelines and medically necessary. The request for EMG and NCV of left lower extremity is not medically necessary.

EMG and NCV of right lower extremity: Upheld

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

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Nerve Conduction Studies and Electromyography (EMG).

Decision rationale: The ODG guidelines state that Nerve Conduction Studies are 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. 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. In this case the medical records do not document complaint of pain, numbness or tingling in the lower extremities. Straight leg raising tests are described as positive however, the nature and extent of those symptoms are not described. There is no indication of any dermatomal pattern for leg symptoms. Although she has been on medications, there is no documentation of efficacy of any conservative treatment in the medical records. MRI of the lumbar spine has been requested but result is not available in the records. There is no indication of likely peripheral neuropathy in the lower extremities. The request for nerve conduction velocity of the right lower extremity is not medically necessary. The MTUS ACOEM guidelines and ODG guidelines note that electromyography (EMG), including H- reflex test, may be useful to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than 3-4 weeks. The ODT guidelines note that electrodiagnostic testing is used to rule out radiculopathy, lumbar plexopathy or peripheral neuropathy. EMGs are recommended as an option (needle, not surface). EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. In this case the medical records do document complaint of low back pain, with pain, motor and sensory deficits in dermatomal patterns in the bilateral lower extremities. Straight leg raising tests are described as positive. The EMG and NCV studies are requested to obtain unequivocal documentation of radiculopathy and help to determine future treatment options, including possible surgery. The MTUS and ODG guidelines clearly state that NCVs are not recommended. EMG however, may be useful to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than 3-4 weeks. A request for EMG of the right lower extremity would be consistent with the guidelines and medically necessary. The request for EMG and NCV of right lower extremity is not medically necessary.