

Case Number:	CM14-0216730		
Date Assigned:	01/06/2015	Date of Injury:	07/30/2013
Decision Date:	02/25/2015	UR Denial Date:	12/03/2014
Priority:	Standard	Application Received:	12/26/2014

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: Ohio, North Carolina, Virginia
 Certification(s)/Specialty: Family Practice

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 sustained a work related injury on July 30, 2013, slipping on a metal pole on a roof and falling, landing on the buttocks, with severe pain reported in the coccyx, ending up hanging from the right foot with a severe pull and pain in the right leg, hip, and foot. On July 12, 2014, the injured worker received therapeutic left medial branch blocks to the lumbar facet joints at the L4-L5 and L5-S1 levels, and a caudal epidural steroid injection with catheterization to L5-S1. On July 19, 2014, the injured worker received a percutaneous epidural decompression neuroplasty of the lumbosacral nerve roots with lumbar facet blocks. A lumbar spine MRI dated October 24, 2014, was noted to show spondylotic changes, end plate sclerotic changes and disc narrowing, congenital stenosis of the thecal sac, L4-L5 a broad based 4-5mm posterior disc protrusion with mild to moderate foraminal narrowing and bilateral exiting nerve root compromise, and L5-S1 with a 4-5mm broad based posterior disc protrusion with moderate to severe foraminal narrowing and bilateral exiting nerve root compromise. The Primary Treating Physician's initial evaluation dated October 22, 2014, noted the injured worker with complaints of constant coccyx and tailbone pain which radiated to the right leg, and was associated with numbness and tingling. The injured worker also complained of constant achy right hip and thigh pain, constant stabbing right knee pain, and constant stabbing right foot pain, with headaches, difficulty sleeping due to pain, depression, and anxiety. Physical examination was noted to show the injured worker with a noticeable antalgic gait, positive straight leg raise particularly on the right side, a positive Kerap test, positive Deyerle's sign on the right, tenderness to palpation of the right hip, pain with passive internal and external rotation of the hip with limited range of

motion due to pain, limited range of motion of the right knee due to pain, and tenderness to palpation of the right ankle with range of motion eliciting pain. The diagnoses were listed as lumbago, lumbar spine radiculitis/neuritis, enthesopathy of the hip, and ankle sprain/strain. The injured worker was noted as not permanent and stationary, and had not reached maximum medical improvement, requiring further treatment. The injured worker was noted to have had poor results with both acupuncture and physical therapies. The Physician requested authorization for a nerve conduction study (NCS) and electromyography (EMG) of the bilateral lower extremities. On December 3, 2014, Utilization Review evaluated the request for a nerve conduction study (NCS) and electromyography (EMG) of the bilateral lower extremities, citing the Official Disability Guidelines (ODG), Low Back, updated November 21, 2014, and the MTUS American College of Occupational and Environmental Medicine (ACOEM). The UR Physician noted that there were no objective physical findings submitted for review, and no documentation of focal neurologic dysfunction, therefore the medical file did not document that the request for a nerve conduction study (NCS) and electromyography (EMG) of the bilateral lower extremities was medically indicated at that time. The UR Physician noted that based on the clinical information submitted for review and using the evidence-based, peer-reviewed guidelines, the request for a nerve conduction study (NCS) and electromyography (EMG) of the bilateral lower extremities was non-certified. The decision was subsequently appealed to Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Nerve Conduction Velocity (NCV) Right Lower Extremity: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back (updated 11/21/14), Nerve conduction studies (NCS)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Low Back

Decision rationale: Nerve conduction studies are not recommended for evaluating potential lower extremity radiculopathy. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. 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 the costly EMG/NCS combination. However, 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 instance, therefore, a nerve conduction test of the right lower extremity is not medically necessary in accordance with the referenced guidelines.

Electromyography (EMG) Right Lower Extremity: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation ODG Low Back (updated 11/21/14)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Low Back

Decision rationale: 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. No correlation was found between intraoperative EMG findings and immediate postoperative pain, but intraoperative spinal cord monitoring is becoming more common and there may be benefit in surgery with major corrective anatomic intervention like fracture or scoliosis or fusion where there is significant stenosis. EMG's may be required by the AMA Guides for an impairment rating of radiculopathy. In this instance, the injured worker has radicular symptoms but no physical findings suggestive of radiculopathy. Therefore, since radiculopathy is not clinically obvious and there has been at least one month of conservative therapy, electromyography of the right lower extremity is medically necessary.