

Case Number:	CM15-0129666		
Date Assigned:	07/16/2015	Date of Injury:	02/17/2014
Decision Date:	08/25/2015	UR Denial Date:	06/12/2015
Priority:	Standard	Application Received:	07/06/2015

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: Texas, New York, California
 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 applicant is a represented 50-year-old who has filed a claim for chronic neck, low back, and hand pain reportedly associated with an industrial injury of February 17, 2014. In a Utilization Review report dated June 12, 2015, the claims administrator failed to approve request for bilateral upper and lower extremity EMG and NCV testing. The claims administrator referenced a June 5, 2015 progress note in its determination. The applicant's attorney subsequently appealed. On April 13, 2015, the applicant reported ongoing complaints of neck and low back pain. The applicant had apparently returned to work. Some radiation of pain to left lateral thigh and left great toe was appreciated. The applicant had been deemed a non-operative candidate by a spine surgeon, it was reported. The applicant was described as having MRI imaging of the lumbar spine demonstrating severe neuroforaminal stenosis at L4-L5 on left side. The applicant also had palmar contracture about the right hand. The applicant was given a diagnosis of lumbar severe segmental spinal stenosis at L4-L5 with associated radiculopathy. The applicant was also described as having cervical stenosis with symptomatic upper extremity radiculopathy. It was suggested that the applicant was approaching permanent and stationary status. In a June 9, 2015, RFA form, electro-diagnostic testing of bilateral upper and bilateral lower extremities was sought. In an associated progress note dated June 5, 2015, the applicant reported ongoing complaints of low back pain radiating to left leg. The attending provider stated that the applicant had consulted a spine surgeon, who declined to intervene operatively. The applicant had also obtained a spine surgery consultation. The spine surgeon also apparently declined to intervene operatively. The attending provider sought authorization for electrodiagnostic testing of the bilateral upper and bilateral lower extremities on the grounds that the applicant had not had prior such testing. The attending provider stated that he needed this testing for impairment rating purposes.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral upper extremity EMG: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303, 309.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182.

Decision rationale: No, the request for bilateral upper extremity EMG testing was not medically necessary, medically appropriate, or indicated here. As noted in the MTUS Chronic Pain Medical Treatment Guideline in ACOEM Chapter 8, table 8-8, page 182, EMG testing is "not recommended" for diagnosis of nerve root involvement if findings of history, physical exam, and imaging study are consistent. Here, the applicant was described as having an established diagnosis of multi-level cervical spinal stenosis with upper extremity radiculopathy on progress notes of April 30, 2015 and June 5, 2015. Thus, the applicant already had a clinically-evident, radiographically-confirmed cervical radiculopathy attributed to cervical spinal stenosis, effectively obviating the need for the EMG request. The attending provider also stated that he was pursuing the proposed EMG testing for academic evaluation and/or impairment rating purposes, without any intention of acting on the results of the same. The requesting provider acknowledged that the applicant was not a candidate for any kind of surgical intervention or interventional spinal procedure involving the cervical spine. It did not appear, thus, that the EMG testing in question would influence or alter the treatment plan. Therefore, the request was not medically necessary.

Bilateral upper extremity NCV: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303, 309.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 261; 272.

Decision rationale: Similarly, the request for a nerve conduction testing of bilateral upper extremities is likewise not medically necessary, medically appropriate, or indicated here. While the MTUS Guideline in ACOEM Chapter 11, page 261 does acknowledge that appropriate electrodiagnostic studies, including the nerve conduction testing at issue, may help to differentiate between carpal tunnel syndrome or other conditions, such as cervical radiculopathy, here, however, there was no mention of the applicant's having suspected carpal tunnel syndrome. Rather, cervical radiculopathy was the sole item on the differential diagnosis list. The attending provider reported on both June 5, 2015 and on April 30, 2015 that he attributed the applicant's

ongoing neck and upper extremity pain complaints to symptomatic cervical spinal stenosis with associated upper extremity radicular symptoms, effectively obviating the need for the nerve conduction testing in question. The MTUS Guideline in Chapter 11, Table 11-7, page 272 also notes that the routine usage of NCV testing in the diagnostic evaluation of nerve entrapment is deemed "not recommended." Here, the attending provider did seemingly state that he was ordering the NCV testing in question for routine evaluation purposes on the grounds that the applicant seemingly had not had such testing and also for the purposes of clarifying the applicant's impairment rating. Such testing, however, ran counter to the philosophy set forth in the MTUS Guideline in ACOEM Chapter 11, table 11-7, page 272. Therefore, the request was not medically necessary.

Bilateral lower extremity EMG: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303, 309.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

Decision rationale: Similarly, the request for bilateral lower extremity EMG testing was likewise not medically necessary, medically appropriate, or indicated here. As noted in the MTUS Guideline in ACOEM Chapter 12, Table 12-8, page 309, imaging testing is "not recommended" for applicants, who carry a diagnosis of clinically obvious radiculopathy. Here, the applicant did apparently have clinically evident, radiographically confirmed lumbar radiculopathy; it was reported on April 30, 2015 and on June 5, 2015. The applicant was described as having severe neuroforaminal stenosis at the L4-L5 level. The attending provider acknowledged that the radiographic nature of the L4-L5 level did account for the applicant's ongoing lower extremity radicular pain complaints, effectively obviating the need for the EMG testing in question. Therefore, the request was not medically necessary.

Bilateral lower extremity NCV: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303, 309.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 377. Decision based on Non-MTUS Citation The Expert Reviewer based his/her decision on the MTUS ACOEM Practice Guidelines, Chapter 14 Ankle and Foot Complaints, page 377 and on the Non-MTUS, ACOEM Occupational Medicine Practice Guidelines, Chronic Pain, 3rd ed., pg. 848 4. Recommendation: Nerve Conduction Studies for Diagnosing Peripheral Systemic Neuropathy Nerve conduction studies are recommended when there is a peripheral systemic neuropathy that is either of uncertain cause or a necessity to document extent confounding or alternate explanatory conditions such as diabetes mellitus. Strength of Evidence Recommended, Insufficient Evidence (I).

Decision rationale: Finally, the request for bilateral lower extremity nerve conduction testing was likewise not medically necessary, medically appropriate, or indicated here. As noted in the MTUS Guideline in ACOEM Chapter 14, table 14-6, page 377, electrical studies (AKA nerve conduction testing) are "not recommended" in absence of clinical evidence of tarsal tunnel syndrome or other entrapment neuropathies. Here, however, lumbar radiculopathy and lumbar spinal stenosis/neuroforaminal stenosis were the sole items on the differential diagnoses list. There was no mention of the applicant's having suspected tarsal tunnel syndrome or other focal entrapment neuropathy. While the Third Edition ACOEM Guidelines Chronic Pain Chapter does recommend nerve conduction studies when there is suspicion of a peripheral systemic neuropathy, here, however, there was no mention of the applicant's having superimposed disease process such as diabetes, alcoholism, hypothyroidisms, hepatitis, etc, which would heighten the applicant's predisposition toward development of a generalized lower extremity peripheral neuropathy. Lumbar radiculopathy was, as noted previously, the sole item of the differential diagnosis list, the treating provider himself acknowledged on office visit of June 5, 2015 and April 30, 2015. Therefore, the request was not medically necessary.