

<b>Case Number:</b>	CM15-0179524		
<b>Date Assigned:</b>	09/21/2015	<b>Date of Injury:</b>	10/21/2014
<b>Decision Date:</b>	10/29/2015	<b>UR Denial Date:</b>	08/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/11/2015

### 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: Georgia, California, Texas  
 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 28 year old male, who sustained an industrial injury on 10-21-14. The injured worker was diagnosed as having chronic lumbago; right lateral meniscal tear; history of right foot fractures healed; right foot peroneal tendonitis; right foot posterior tibial tendonitis-tarsal tunnel syndrome; arthrofibrosis right ankle. Treatment to date has included physical therapy evaluation (2-5-15); physical therapy; urine drug screening; medications. Diagnostics studies included MRI right knee (2-4-15); MRI thoracic spine (2-4-15). Currently, the PR-2 notes dated 6-24-15 indicated the injured worker was in the office for an orthopedic surgical consultation. The injured worker reports to this provider "he has ongoing pain in the back radiating into the right buttocks, worse with sitting, with standing, he has increased right knee pain, more so on the lateral aspect, with locking. He has right heel pain, and with prolonged standing pain in the dorsal aspect of the right heel." The injured worker reports to the provider his industrial injury resulting in this pain in his right ankle and heel, as well as right knee and low back. He reports he was initially treated for "a broken ankle and broken heel. He was treated with "a fracture boot, but was eventually told that his fractures healed and was referred to physical therapy." His current medications are listed as: Ibuprofen, Norco and Tramadol and given prescriptions for: Anaprox DS 550mg and Ultram 50mg. The injured worker reports he has had no surgeries related to this injury or in his past. On physical examination, the provider documents: "The patient walks with a normal gait and has a normal heel-toe swing-through gait, with no evidence of limp. There is no evidence of weakness walking on the toes or heels. There is no gross deformity. There is no appreciable swelling or gross atrophy of the paravertebral

muscles. There is no evidence of scoliosis and there is normal lordosis. In palpation there is palpable tenderness over the mild lumbosacral junction, as well as over the right sacroiliac joint. Dorsalis pedis, posterior tibial pulses are present. Sensory to light touch and pinprick are intact in the bilateral lower extremities. Straight leg raise is negative bilaterally at 90 degrees. Sacroiliac joint provocative testing: Positive Fortin's on the right. Positive posterior thigh thrust on the right, Negative pelvic distraction on the right, Negative pelvic compression on the right. There is mild effusion of the right knee. There is palpable tenderness over the lateral joint line on the right. There is no diminished motion of the patella. There is no crepitation of the patella bilaterally. Patellar compression test causes no discomfort. Apprehension test is negative bilaterally. McMurry's test is positive with palpable pop. The right knee is stable to varus and valgus stress. Ankle: There are no trophic changes. There is no evidence of atrophy. There is no erythema. There is tenderness over the distal tibia over the medial malleolus. There is minimal tenderness over the lateral malleolus. There is tenderness over the peroneal tendons with eversion and inversion. Positive Tinel's over the right tarsal tunnel." A MRI of the right knee was done on 2-4-15 with an impression revealing: "1) Fraying of the superior articular surface of the body of the medial meniscus. 2) Low-grade chondromalacia with in the medial femorotibial and patellofemoral compartment." A MRI of the thoracic spine dated 2-4-15 impression reveals: "Normal MRI examination of the thoracic spine, without evidence of disc protrusion or neural impingement. There is partial visualization of a 1.6cm left adrenal gland nodule." The provider's treatment plan includes physical therapy and a request of the actual X-rays to show the fractures specifically. He has requested an EMG-NCV of the lower extremities to rule out tarsal tunnel syndrome due to his tenderness and complaints of electrical symptoms. He also wants a right ankle MRI. A Request for Authorization is dated 9-11-15. A Utilization Review letter is dated 8-12-15 and modified the certification for EMG-NCV of the lower extremities. The Utilization Review modification authorized a NCV of the right lower extremity only. Utilization Review stated "There is no evidence of pathology to the spine which would indicate the need for an EMG of the lower extremities. Additionally, there is no evidence of pathology to the left lower extremity. Therefore, this request is modified for the NCV of the right lower extremity." The provider is requesting authorization of EMG-NCV of the lower extremities.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**EMG/NCV of the lower extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back-Lumbar & Thoracic (Acute & Chronic), EMGs (electromyography).

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies, and Ankle and Foot Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation ODG Forearm, Wrist & Hand (Acute & Chronic, revised 6/29/15), Electrodiagnostic studies (EDS).

**Decision rationale:** ACOEM Guidelines 2004 edition recommends consideration of special studies for patients with symptoms persisting despite a 4-6 week course of conservative

treatment. Based upon clinical findings (positive Tinel's sign over the right tarsal tunnel) suggesting of tarsal tunnel syndrome, performance of right lower extremity nerve conduction studies is reasonable and medically necessary. Because MTUS is silent concerning bilateral studies, ODG was also consulted. The ODG lower extremity chapters were silent concerning this question. ODG Forearm, Wrist & Hand Chapter states: "Bilateral studies: Bilateral EMG is generally not necessary, but NCS may be necessary for comparison, depending on the results found on the affected side. If the NCS results are clearly abnormal, comparison is not necessary. If they are clearly normal, comparison is not necessary. However, if the results are borderline, the use of the unaffected side to get the closest measure of normal is appropriate since the standard is to use population normal, and a particular patient may be an outlier and test interpretation can be affected by this. The decision to test or not test the unaffected side should be made during the examination, which requires a conscientious examiner who is actively interpreting results as they occur (e.g. not reviewing a technician's results after the fact). There are a variety of reasons for bilateral NCS. Bilateral NCS results may be important, first, for diagnosis (clinical symptoms and physical examination matched to conduction delay on symptomatic side vs. the non-symptomatic side to provide insight into diagnosis, treatment and outcomes). Second is related to causation to evaluate if the job may be the cause, and bilateral NCT can help with this determination. Third is related to response to treatment and expectations for return to work. Fourth, bilateral can help with apportionment if an impairment rating is required. Finally, the cost for a bilateral NCT is much less than the cost for one sided NCT/EMG. EMG on the asymptomatic side is not required. (Melhorn, 2013) (Dumitru, 2001)" ODG would support bilateral nerve conduction studies in this case. Due to history of low back pain and right lower extremity pain, ODG would support right sided EMG studies. However, EMG studies of the asymptomatic side are not supported. Because this request includes bilateral EMG studies, it fails to meet evidence-based criteria. Therefore, medical necessity is not established for EMG and nerve conduction studies of the bilateral lower extremities, therefore is not medically necessary.