Case Number:	CM13-0048427		
Date Assigned:	12/27/2013	**Date of Injury:**	07/01/2010
Decision Date:	02/28/2015	**UR Denial Date:**	10/16/2013
Priority:	Standard	**Application Received:**	11/05/2013

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, Indiana, New York
Certification(s)/Specialty: Internal 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:

This 54 year old male was injured 7/1/10 when he fell approximately 10 feet from a ladder that folded up. This caused him to step back and then he fell through a ceiling landing on his back and buttock. He developed a back bruise, neck pain, back pain and left index finger pain and numbness. The incident was reported but he did not receive medical attention for six months during which time he had continued pain. He then had radiographs and MRI's of the neck, low back and right elbow but results were not provided. He was treated with medications, physical therapy which increased his pain level and injection into the neck which offered no relief. On 10/19/11 he had an electromyography (EMG) and nerve conduction studies (NCS) which showed a pinched nerve. EMG (5/29/12) demonstrated chronic right C7 and S1 radiculopathies; left upper and lower extremity EMG normal and NCS (5/29/12) demonstrated right S1 radiculopathy; mild right peroneal motor neuropathy at the ankle; mild right ulnar motor neuropathy at the elbow; severe bilateral median sensory neuropathy with sites of lesion possibly at the wrists and severe bilateral ulnar sensory neuropathy with possible sites of lesion at the elbows. He underwent left carpal tunnel release and elbow surgery in 2012 and prescribed post-operative therapy which was beneficial. On 7/30/13 he underwent right carpal tunnel release and right ulnar external neurolysis of the ulnar nerve at the elbow and modified medial epicondylectomy and underwent physical therapy which increased his pain level. He currently complained of popping sensation and constant sharp pain in the neck radiating into both arms with numbness and tingling in both arms. In addition he had constant, burning pain in the low back with radiation into the legs, numbness and tingling that was worse with prolonged sitting,

standing and repetitive bending. He has difficulty performing most activities of daily living. On physical exam: the cervical spine had moderate bilateral trapezial trigger points and his range of motion is decreased; dorsolumbar spine and lower extremities demonstrated focal tenderness along L4-5 and L5-S1 posterior spinous process and paraspinal muscles with decreased range of motion. Straight leg raise is positive for calf and foot pain bilaterally and Lasegue's and Bragard tests are positive on the left. He demonstrated marked decrease sensation in the L5-S1 nerve root distribution to the left foot. MRI (7/9/12) of the cervical spine demonstrated multilevel degenerative disc disease; C5-6 degenerative disc with mild focal stenosis. Lumbar MRI (7/9/12) demonstrated moderate degenerative disc at L5-S1 with modic changes and focal spinal stenosis at L5-S1 and mild disc protrusion at L4-5. His diagnoses include bilateral trapezial trigger points; bilateral elbow ulnar neuropathy (status post anterior nerve transpositions bilaterally; bilateral carpal tunnel syndrome (status post bilateral release; cervical degenerative disc disease at C5-6 and also L5-S1 and left greater than right L5-S1 radiculopathy. His medications include Nucynta and Lyrica. Laboratory evaluations (4/22/13 and 8/19/13) to determine level of prescription medications were positive for cannabinoids and Xanax. .He had occupational therapy for the right wrist and elbow and experienced right elbow swelling with activity but stiffness is decreasing and is making steady progress. The injured worker last worked in 20 11 and is temporarily totally disabled. Of note, his past significant medical history includes a work related injury in 2002 to his back; 2 motorcycle accidents in the 1990;s where he sustained injuries to his back, neck and left leg and underwent 2 back and 2 neck surgeries.On 10/16/13 Utilization Review (UR) non-certified the request for NCV bilateral lower extremities based on guideline recommendations that nerve conduction studies are not recommended to clarify nerve root dysfunction. The injured worker was noted to have progressive symptoms of radiculopathy of bilateral lower extremity only. MTUS Low Back Complaints and ODG Low Back were referenced.

IMR ISSUES, DECISIONS AND RATIONALES

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

NCV LEFT 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, 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, NCV

Decision rationale: Pursuant to the Official Disability Guidelines, nerve conduction velocity studies left lower extremity are not medically necessary. Nerve conduction studies are not recommended. There is minimal justification for performing nerve conduction studies when the patient is presumed to have symptoms on the basis of radiculopathy. In the management of spine trauma with radicular symptoms, no deduction studies/EMG often have low combined sensitivity and specificity in confirming injury and there is limited evidence supports the use of and often uncomfortable and costly EMG/NCS. In this case, the injured workers working diagnoses are bilateral trapezius trigger points; bilateral ulnar neuropathy; status post anterior ulnar nerve

transpositions bilaterally; bilateral carpal tunnel syndrome, status post bilateral releases; cervical degenerative disc disease at C5; and right L5-S1 radiculopathy; and degenerative disc disease at L5-S1. Injured worker complains of burning pain in the lower back with radiation to the legs left greater than right. Straight leg raising is positive on the right and left. There is decreased sensation in the L5-S1 nerve root distribution to his left foot. The guidelines indicate there is minimal justification for performing nerve conduction studies when the patient is presumed to have symptoms on the basis of radiculopathy. Consequently, absent clinical guideline recommendations to perform a nerve conduction study, nerve conduction velocity studies of the left lower extremity are not medically necessary.

NCV (NERVE CONDUCTION VELOCITY) 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, 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, NCV

Decision rationale: Pursuant to the Official Disability Guidelines, nerve conduction velocity studies right lower extremity are not medically necessary. Nerve conduction studies are not recommended. There is minimal justification for performing nerve conduction studies when the patient is presumed to have symptoms on the basis of radiculopathy. In the management of spine trauma with radicular symptoms, no deduction studies/EMG often have low combined sensitivity and specificity in confirming injury and there is limited evidence supports the use of and often uncomfortable and costly EMG/NCS. In this case, the injured workers working diagnoses are bilateral trapezius trigger points; bilateral ulnar neuropathy; status post anterior ulnar nerve transpositions bilaterally; bilateral carpal tunnel syndrome, status post bilateral releases; cervical degenerative disc disease at C5; [and right L5-S1 radiculopathy; and degenerative disc disease at L5-S1. Injured worker complains of burning pain in the lower back with radiation to the legs left greater than right. Straight leg raising is positive on the right and left. There is decreased sensation in the L5-S1 nerve root distribution to his left foot. The guidelines indicate there is minimal justification for performing nerve conduction studies when the patient is presumed to have symptoms on the basis of radiculopathy. Consequently, absent clinical guideline recommendations to perform a nerve conduction study, nerve conduction velocity studies of the right lower extremity are not medically necessary.