

Case Number:	CM13-0032837		
Date Assigned:	05/21/2014	Date of Injury:	08/11/2012
Decision Date:	07/11/2014	UR Denial Date:	09/27/2013
Priority:	Standard	Application Received:	10/07/2013

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

There is a 7/13/13 follow up consultation that states that the patient complains of 7/10 left plantar foot pain and left Achilles pain. Patient states that medications decrease pain. On physical exam there is tenderness in the left plantar foot. The patient favors right lower extremity with ambulation. She is Neurologically grossly unchanged. Spasm of the muscles of the foot less pronounced. There is a request for EMG/NCS of the bilateral lower extremities (BLE) and a plan to proceed with therapy three times a week for 4 weeks to the left foot.

IMR ISSUES, DECISIONS AND RATIONALES

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

ADDITIONAL PHYSICAL THERAPY 3 TIMES 4 FOR THE LEFT FOOT: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: Additional physical therapy three times four for the left foot is not medically necessary per the Chronic Pain Medical Treatment Guidelines. The MTUS guidelines states that up to 10 visits are appropriate for the patient's condition. The request for 12 more visits exceeds

this recommended number. The patient has already had 12 visits of physical therapy without significant improvement in function or decrease in pain. The patient should be independent in a home exercise program at this point. Therefore, the request for additional physical therapy three times four for the left foot is not medically necessary.

ELECTROMYOGRAPHY (EMG) OF BILATERAL LOWER EXTREMITIES: Upheld

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

MAXIMUS guideline: Decision based on MTUS American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Ankle and Foot Complaints page 366; Chronic Pain Medical Treatment Guidelines Complex Regional Pain Syndrome (CRPS) pages 35-37 and Other Medical Treatment Guideline or Medical Evidence: Muscle Nerve 31: 520–527, 2005.

Decision rationale: The ACOEM guidelines state that peripheral nerve entrapment may be manifested as foot drop if the peroneal nerve at the knee is involved or rarely, as a tarsal tunnel syndrome, presenting as numbness of the plantar surface of the foot and toes. The ODG states that electrodiagnostic testing should be performed only if medically indicated. The documentation submitted reveals no indication that electrodiagnostic testing is necessary in the BLE. There is no evidence of objective findings in the right lower extremity that warrants electrodiagnostic testing. In regards to the left lower extremity the ODG states that the later development of sympathetically mediated symptomatology has no pathognomonic pattern of abnormality on EMG/NCS. The ODG states that in the Low Back Chapter, EMG is 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. The documentation submitted reveals no evidence of foot drop due to weakness of ankle dorsiflexion which the AANEM states is the most common presentation of a peroneal neuropathy. There is no documentation of decreased sensation in a peroneal sensory nerve distribution. There is no documentation that symptoms may be suspected to be radicular in nature. The criteria that electrodiagnostic testing should be performed only if medically indicated are not met. Therefore, the request for electromyography (EMG) of the bilateral lower extremities is not medically necessary.

NERVE CONDUCTION STUDY (NCV) OF BILATERAL LOWER EXTREMITIES:
Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 366, Chronic Pain Treatment Guidelines Complex Regional Pain Syndrome (CRPS) Page(s): 35-37. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Muscle Nerve 31: 520-527, 2005, Practice Parameter: Utility of electrodiagnostic techniques in evaluating patients with suspected peroneal neuropathy and evidence based review.

Decision rationale: The ACOEM guidelines state that peripheral nerve entrapment may be manifested as foot drop if the peroneal nerve at the knee is involved or rarely, as a tarsal tunnel syndrome, presenting as numbness of the plantar surface of the foot and toes. The ODG states that electrodiagnostic testing should be performed only if medically indicated. The documentation submitted reveals no indication that electrodiagnostic testing is necessary in the BLE. There is no evidence of objective findings in the right lower extremity that warrants electrodiagnostic testing. In regards to the left lower extremity the ODG states that the later development of sympathetically mediated symptomatology has no pathognomonic pattern of abnormality on EMG/NCS. The ODG states that in the Low Back Chapter, EMG is 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. The documentation submitted reveals no evidence of foot drop due to weakness of ankle dorsiflexion which the AANEM states is the most common presentation of a peroneal neuropathy. There is no documentation of decreased sensation in a peroneal sensory nerve distribution. There is no documentation that symptoms may be suspected to be radicular in nature. The criteria that electrodiagnostic testing should be performed only if medically indicated are not met. Therefore, the request for nerve conduction study (NCV) of the bilateral lower extremities is not medically necessary.