

Case Number:	CM13-0055756		
Date Assigned:	04/28/2014	Date of Injury:	05/21/2012
Decision Date:	06/11/2014	UR Denial Date:	11/05/2013
Priority:	Standard	Application Received:	11/21/2013

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 Occupational Medicine and is licensed to practice in California. 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:

The patient is a 59 year old female who was injured on 05/21/2012 while she slipped on something that was on the floor, falling onto her left knee. Prior treatment history has included physical therapy, aggressive home based strengthening exercises, TENS unit and a walker. The patient underwent open reduction and internal fixation. PR-2 dated 08/19/2013 documented the patient with complaints of intermittent pain in the left knee and radiating pain to the entire leg occurring when she pulls her back or strains. Tingling and burning were denied. The patient indicates she has been taking Lopressor, Tramadol, Tylenol and ibuprofen as needed. Objective findings on exam reveal she has significant atrophy of an inch and a half on the thigh and an inch on the calf, measuring equal above and below the kneecap. Right thigh specifically measures 24 inches, left 22.5 inches. The calf is 17 on the right and 16 on the left. She has some dyesthesias to light touch of the entire left lower extremity with some changes in nail pattern and discoloration of the skin that is slightly blue. Examination of the lumbar spine reveals muscle strength with resistance to hip flexion and extension is 5/5, knee flexion and extension 4/5 on left and 5/5 on right. Ankle flexion and extension is 4/5 on the left and 5/5 on right. Reflexes are 2+ and symmetric. On sensory exam, there are dyesthesias to light touch to her thigh, calf, ankle and foot. PR-2 dated 09/23/2013 documented the patient has undergone a series of bone scans. It shows atypical response, which can be consistent with complex regional pain syndrome. This is one tool that can be used as an indicator that additional treatment and testing made available, specifically a stellate ganglion block. We note that she has improved with the therapy that she has had. The diagnoses include fracture of the left patella, status post open reduction and internal fixation, arthroscopic lysis of adhesions and persistent pain and weakness in the left leg and knee consistent with some dyesthesias that may be consistent with complex regional syndrome. The

treatment plan is for a nerve test to be accomplished as well as the neoprene brace, wrap around with hinges.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG TO BILATERAL LOWER EXTREMITIES: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 11th Edition, 2013, Pain, Electrodiagnostic Testing.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, CRPS, Pathophysiology, Electrodiagnostic testing (EMG/NCS).

Decision rationale: According to the Official Disability Guidelines, EMG and NCS are separate studies and should not necessarily be done together. In the Low Back Chapter, the guidelines state NCS is not recommended, but 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. Radiculopathy is not clinically obvious in this case of chronic pain. There are complaints of low back pain with pain radiation to the left lower extremity along with dysesthesias, weakness, and muscle atrophy on examination, which do not appear to follow dermatomal levels. Diagnostic considerations include CRPS and radiculopathy. EMG is warranted in this case to further define pathology and is supported by guidelines.

NCS TO BILATERAL LOWER EXTREMITIES: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 11th Edition, 2013, Pain, Electrodiagnostic Testing.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, CRPS Diagnostic Tests.

Decision rationale: The Official Disability Guidelines recommend assessment of clinical findings as the most useful method of establishing the diagnosis of CRPS. See CRPS, Pathophysiology (clinical presentation & diagnostic criteria). The guidelines recommend using a combination of criteria as per the revised Budapest (Harden) criteria as indicated below to make this diagnosis. A gold standard for diagnosis of CRPS has not been established and no test has been proven to diagnose this condition. Assessment of clinical findings is currently suggested as the most useful method of establishing the diagnosis. Nerve conduction velocity can be considered as recommended to investigate the presence of nerve injury/neuropathy and differentiate between CRPS I and II. According to the medical records, the patient has already

undergone a series of bone scans, with findings suggestive of CRPS of the left lower extremity. The guidelines state assessment of clinical findings is currently suggested as the most useful method of establishing the diagnosis. The medical records do not demonstrate whether the recommended criteria for diagnosis have been met. Nevertheless, given the reported subjective/objective findings, further assessment would be prudent, and NCS would be useful in differential diagnosis.