

Case Number:	CM13-0064863		
Date Assigned:	01/17/2014	Date of Injury:	12/08/2011
Decision Date:	05/20/2014	UR Denial Date:	11/12/2013
Priority:	Standard	Application Received:	12/12/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a Physician Reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The Physician Reviewer is Board Certified in Physical Medicine & Rehabilitation, and is licensed to practice in Texas. 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 Physician 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 injured worker is a 66-year-old male who reported an injury on 12/08/2011. The mechanism of injury was not provided. The documentation of 08/05/2013 revealed that the injured worker had complaints of status post right knee arthroscopy with residual pain. The pain was rated at a 9/10 on the pain scale. The injured worker had sensation intact; motor strength was 4/5 in the lower extremity. The diagnoses included right knee internal derangement and status post right knee arthroscopy with residual pain. The plan included an EMG/NCV of the right lower extremity and an orthopedic surgeon consultation as well as shockwave therapy. The EMG/NCV study was originally ordered on 07/08/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

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

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation ACOEM PRACTICE GUIDELINES, 2ND EDITION (2004)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), LOW BACK CHAPTER, NCS

Decision rationale: The Official Disability Guidelines do not recommend NCS as there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. The clinical documentation submitted for review indicated that the injured worker had signs and symptoms of radiculopathy on the right. There were no documented signs, symptoms or findings on the left. There was a lack of documentation indicating the necessity for both a nerve conduction study and an EMG and for the bilateral extremities. Given the above, the request for a nerve conduction velocity study of the bilateral lower extremities is not medically necessary.

ELECTROMYOGRAPHY (EMG) OF THE BILATERAL LOWER EXTREMITIES:

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), ([HTTP://WWW.ODG-TWC.COM/ODGTWC/LOW_BACK.HTM](http://www.odg-twc.com/odgtwc/low_back.htm))

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation ACOEM PRACTICE GUIDELINES, 2ND EDITION (2004)

Decision rationale: The ACOEM guidelines indicate that Electromyography (EMG), including H reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. The clinical documentation submitted for review indicated that the injured worker had objective findings of motor strength at a 4/5 in the right lower extremity. There was a lack of documentation indicating a necessity for bilateral testing. Given the above, the request for electromyography of the bilateral lower extremities is not medically necessary.

SHOCKWAVE THERAPY: 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), ([HTTP://WWW.ODG-TWC.COM/ODGTWC/KNEE.HTM](http://www.odg-twc.com/odgtwc/knee.htm))

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation WANG, CHING-JEN. "EXTRACORPOREAL SHOCKWAVE THERAPY IN MUSCULOSKELETAL DISORDERS" JOURNAL OF ORTHOPAEDIC SURGERY AND RESEARCH 7.1 (2012): 1-8

Decision rationale: According to Wang, Ching-Jen (2012), "The application of extracorporeal shockwave therapy (ESWT) in musculoskeletal disorders has been around for more than a decade and is primarily used in the treatment of sports related over-use tendinopathies such as proximal plantar fasciitis of the heel, lateral epicondylitis of the elbow, calcific or non-calcific tendonitis of the shoulder and patellar tendinopathy etc." The clinical documentation submitted for review failed to provide the rationale for the shockwaver therapy. The request as submitted

failed to indicate the quantity as well as the body part to be treated with shockwave therapy. Given the above, the request for shockwave therapy is not medically necessary.

REFERRAL TO ORTHOPEDIC SURGEON: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation INDEPENDENT MEDICAL EXAMINATIONS AND CONSULTATIONS CHAPTER (ACOEM PRACTICE GUIDELINES, 2ND EDITION (2004), CHAPTER 7)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM PRACTICE GUIDELINES, 2ND EDITION (2004), CHAPTER 6, PAGE 163

Decision rationale: The ACOEM Guidelines indicate that a consultation is intended to aid therapeutic management. The clinical documentation submitted for review indicated that the injured worker had continuing pain after a right knee arthroscopy. However, the request as submitted was for a referral to an orthopedic surgeon without indication as to the body part to be treated by the orthopedic surgeon and what type of orthopedic surgeon was being requested. Given the above, the request for a referral to an orthopedic surgeon is not medically necessary.

DME (UNSPECIFIED): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), KNEE & LEG CHAPTER, DME

Decision rationale: The Official Disability Guidelines recommend durable medical equipment (DME) if a system or device meets Medicare's definition of a DME. DME is able to withstand repeated use, as in could normally be rented, and used by successive patients and is primarily and customarily used to serve a medical purpose and is not useful to a person in the absence of illness or injury, but is appropriate for use in a patient's home. The clinical documentation submitted for review failed to indicate what DME was being requested. As such, there could be no further application of guidelines.