

Case Number:	CM14-0000234		
Date Assigned:	07/02/2014	Date of Injury:	04/05/2013
Decision Date:	08/07/2014	UR Denial Date:	12/03/2013
Priority:	Standard	Application Received:	01/02/2014

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 Emergency 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:

This patient with a reported date of injury on 4/5/2013. Mechanism of injury is described as a slip and fall at work. Patient has a diagnosis of lumbar sprain/strain, lumbar radiculopathy, lumbar disc herniation (no supporting MRI was provided to support this diagnosis), bilateral knee sprain/strain, stress/anxiety and depression. Medical records reviewed. Last available report available until 11/27/13. Patient complains of low back pain 5/10. Pain is burning radicular radiating to both lower extremities associated with numbness and tingling, Worsened with prolonged sitting, standing or activity. Objective exam by chiropractor and treating physician are contradictory. As per chiropractor's reports, patient has muscle strength in legs are reportedly normal. Range of motion of lumbar spine is diffuse decreased, especially on flexion. Sensation in both lower extremities are normal. The most recent Primary treating physician's objective exam does not report anything except for pain on palpation and muscle spasms. No neurological exam was provided. An older exam from before 10/13 shows decreased L4-5 dermatome sensation. Straight leg raise up to 80 degrees to elicit pain in one note and 35 degrees in another. Slump test, sacroiliac challenge and FABER test reportedly increases pain. Strength was normal except for minimally decreased in left hamstring and right tibialis anterior. There is a single line in one of the primary treating charts mentioning that an MRI was done (or requested?) but no MRI report was provided for review. No medication list was provided. Reportedly on ketoprofen gel and multiple compounded, non FDA approved compounded products and dietary substances such as Cyclophane cream, Synapryn, Tabradol, Deprizine, Dicopanol and Fanatrex. The patient has completed physical therapy and TENS. No prior treatments were noted. This Independent Medical Review is for EMG of bilateral lower extremities, NCV of bilateral lower extremities and shockwave therapy. Prior UR on 12/3/13 recommends non-certification. UR on 7/20/13 and 9/5/13 also recommended non-certification.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG BILATERAL LOWER EXTREMITIES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

Decision rationale: As per ACOEM guidelines, EMG may be recommended in situations where nerve dysfunction needs to be clarified after 1month of conservative therapy. However, the treating provider's documentation does not support a case for EMG. The documentation provided is contradictory with missing exams in many recent PR2 reports and a lack of justification for need of EMG. There has also been no attempt at treating the symptoms with appropriate medications and no report of any change in the symptoms. The provided documentation fails to support the medical necessity of EMG of bilateral lower extremities. EMG is not medically necessary.

SHOCKWAVE THERAPY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ESWT (Extracorporeal shockwave therapy).

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-Lumbar and Thoracic(Acute and Chronic), Shockwave Therapy.

Decision rationale: This topic is not covered in the MTUS Chronic Pain or ACOEM Guidelines. As per Official Disability Guidelines, Shockwave therapy is not recommended for low back pain. There is no evidence to supports its use. The request for Shockwave Therapy is not medically necessary.

NCV BILATERAL LOWER EXTREMITIES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 377.

Decision rationale: As per ACOEM Guidelines, electrophysiologic studies in legs are not recommended unless there are signs of an entrapment neuropathy. Reviewing the Knee Chapter

in ACOEM also states the same recommendation. The patient does not meet guidelines for an EMG, for radiculopathy and the provided documentation also fails to support any necessity for NCV. NCV is not medically necessary.