

<b>Case Number:</b>	CM14-0004601		
<b>Date Assigned:</b>	07/16/2014	<b>Date of Injury:</b>	10/25/2012
<b>Decision Date:</b>	08/19/2014	<b>UR Denial Date:</b>	12/09/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/10/2014

### 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 Physical Medicine and Rehabilitation, Sports Medicine and is licensed to practice in New York and 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 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 injured worker is a 56-year-old female who reported an injury on 10/25/2012. The mechanism of injury was noted to be lifting a machine index. The treatments included medications, sling, ice, physical therapy, injections, and surgery. The diagnoses were noted to be acromioclavicular osteoarthritis, supraspinatus tendinitis, infraspinatus tendinitis, subscapularis tendinitis, and small joint effusion. A primary treating physician's progress report dated 12/11/2013 indicated the injured worker with complaints of neck pain with spasms, right shoulder pain, bilateral elbow pain with spasms, bilateral wrist pain with spasms, mid-back pain with spasms, low back pain with spasms, bilateral knee pain with spasms, and bilateral ankle pain with spasms. The examination noted the anterior head carriage with right lateral head tilt. The bilateral shoulder examination noted crepitus with range of motion. There was tenderness at the GH joint and tenderness to palpation at the supraspinatus muscles as well as tendon attachment sites. There was tenderness to palpation at the rotator cuff tendon attachment sites on the left. There was tenderness over the lateral epicondyle of the elbow examination. The wrist examination noted tenderness at the carpal tunnel and at the 4th and 5th dorsal extensor muscle compartment on the right. There was also tenderness to palpation over the carpal bones and at the flexor tendon attachment sites on the left. There was sensation to pinprick and light touch diminished over the C7 and C8 dermatomes in the bilateral upper extremities. The thoracic spine examination noted tenderness to palpation over the spinous process T3 through T5, bilateral with muscle guarding. Sensation to pinprick and light touch was intact over T1, T2, T3, T4, T5, T6, T7, T8, T9, T10, T11, and T12, bilaterally. The lumbar spine examination noted the injured worker ambulated with an abnormal gait. The bilateral knee examination noted tenderness to palpation over the medial joint line and at the lateral joint line as well; tenderness to palpation at the patellofemoral joint on the right. There was tenderness to palpation over the medial and

lateral joint line on the left. The bilateral ankle examination noted tenderness to palpation at the right anterior talofibular ligament. There was tenderness to palpation over the medial and lateral malleolus. There was diminished sensation to pinwheel and sharp touch at the L5 and S1 dermatomes bilaterally. The treatment plan was for medications and a periodic urinalysis to be performed for toxicological evaluation. Physical therapy and acupuncture were prescribed. An LSO brace and TENS unit were to be ordered as well as a referral to a psychologist for surgery. The provider's rationale was not provided within the documentation submitted for review. A request for authorization for medical treatment was not provided within the documentation for review.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**EMG of the 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): 308-310. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, EMG's.

**Decision rationale:** The request for an EMG of the bilateral lower extremities is not medically necessary. The California MTUS/American College of Occupational and Environmental Medicine Guidelines recommend the detection of physiologic abnormalities, if no improvement after 1 month, consider needle EMG and H-reflex tests to clarify nerve root dysfunction. The guidelines do not recommend an EMG for clinically obvious radiculopathy. The ODG state EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 1 month of conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious. A primary treating physician's progress report dated 12/11/2013 indicated objective findings of radiculopathy. Radiculopathy was also noted within the diagnoses section of this progress report. According to the guidelines, when radiculopathy is clinically obvious, an EMG is not recommended. Therefore, the request for an EMG of bilateral lower extremities is not medically necessary.

**NCV for the bilateral lower extremities:** Upheld

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

**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, Nerve conduction studies.

**Decision rationale:** The request for an NCV of the bilateral lower extremities is not medically necessary. The ODG do not recommend nerve conduction studies as there is minimal

justification for performing nerve conduction studies when an injured worker is presumed to have symptoms on the basis of radiculopathy. The primary treating physician's progress report dated 12/11/2013 noted radiculopathy in the diagnoses. The guidelines indicate that nerve conduction studies are not recommended, and have low sensitivity and specificity when combined with EMGs. NCVs are performed when there is evidence of peripheral neuropathy. There was lack of evidence to suggest peripheral neuropathy to warrant a nerve conduction velocity. As such, the request for an NCV for the bilateral lower extremities is not medically necessary.