

<b>Case Number:</b>	CM14-0131597		
<b>Date Assigned:</b>	09/08/2014	<b>Date of Injury:</b>	09/17/2008
<b>Decision Date:</b>	10/14/2014	<b>UR Denial Date:</b>	08/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/18/2014

### 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 Anesthesia, has a subspecialty in Acupuncture & Pain 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:

40 year old female injured worker with date of injury 9/17/08 with related low back and bilateral knee pain. Per progress report dated 7/15/14, it was noted that she was status post two surgeries on the left knee, the last being synovectomy of the knee and meniscectomy. It appeared that the latter resulted in deep vein thrombosis. She had treated the right knee conservatively. Per physical exam, tenderness along the joint line was noted as well as patella with weakness to resisted function. Left knee MRI on 8/23/12 showed oblique tear of the midbody of posterior horn of the medial meniscus extending to the undersurface measuring approximately 5-6 mm and slight peripheral extrusion of the meniscus tissue, also slight laxity of the anterior cruciate ligament suggestive of ACL sprain, edema, and laxity of the medial collateral ligament suspicious for sprain, small joint effusion, as well as popliteal cyst measuring 13 mm in diameter. Right knee MRI on 1/13/12 showed at the lateral joint compartment slight altered signal and contour of the anterior root of the lateral meniscus proximal parameniscal cyst extending anteriorly from the anterior root of the lateral meniscus measuring 4 mm compatible tear of the anterior root and anterior horn of the lateral meniscus extending to the upper surface of the parameniscal cyst as well as signs of small joint effusion. MRI of the lumbar spine dated 1/2012 revealed facet wear greater on the left than the right at L5-S1. Treatment to date has included surgery, TENS, physical therapy, and medication management. The date of UR decision was 8/1/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**NCV (Nerve Conduction Velocity ) Right Lower Extremity: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, TREATMENT INDEX, 11TH EDITION (WEB), 2014, LOW BACK CHAPTER, NERVE CONDUCTION STUDIES

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177.

**Decision rationale:** ACOEM guidelines support ordering of imaging studies for emergence of red flags, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. The documentation submitted for review includes no red flag signs related to the bilateral lower extremities. The injured worker has no signs of peripheral nerve entrapment as no peripheral neuropathy testing was documented. It was not specified why this request was made. The request is not medically necessary.

**EMG (Electromyography) Left Lower Extremity: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177.

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