MAXIMUS Federal Services

Case Number:	CM14-0141759		
Date Assigned:	09/10/2014	Date of Injury:	10/31/2012
Decision Date:	11/17/2014	UR Denial Date:	08/18/2014
Priority:	Standard	Application Received:	09/02/2014

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 Physical Medicine & Rehabilitation 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 injured worker (IW) is a 34-year-old man with a date of injury of October 31, 2012. The IW was lifting a piece of wood with a nail in it. He did not notice the nail and it got stuck in his right knee. This caused him to lose his balance and fall about 10 feet. Pursuant to the First Report of Occupational Injury dated July 28, 2014, which was handwritten with parts being illegible, the IW complains of right knee pain, and low back pain. Objective findings reveal L/S bilateral side tenderness, Flex 65, ext 30, lateral bend 35/30, ext knee. Knees Right prepatellar tenderness, flex 135, ext 6?, flex pain. Diagnoses include: Lumbar radiculopathy, and right knee internal derangement. Treatment: UA for toxicology and med compliance, topical compound creams ordered, FCE, MRI L/S Right knee. EMG/NCV lower ext. TEN unit, pain management. There was a follow-up progress report dated July 23, 2014 (date does not coincide as being a follow-up as the date of service is 7/23/14, which would indicate the note was written prior to the first occupational report) that states the IW complains of pain mostly in his right knee and low back, which comes and goes. Most of the pain occurs when he is walking, the knee locks. The rest of the subjective complaint is illegible in the handwritten report. Objective finding in the handwritten note that is partly illegible indicates back pain going into the low back and down the back of the (?) leg and left thigh, into the (?) calf. Cramping, and numbness when walking. He feels weakness like it's going to collapse. Diagnoses documented are: Lumbar sprain/strain and right knee sprain. Treatment includes: Ortho pain management; chiropractic PT - 2 times a week for 6 weeks; acupuncture, 1 time a week for 6 weeks; UA for drug compliance, topical cream, and L/S knee support. MRI of the right knee dated July 28, 2014 reveled: 1. Abnormality of the posterior horn of the medial meniscus representing a tear. 2. Abnormality of the posterior horn of the lateral meniscus representing a tear. MRI of the lumbar spine dated May 30, 2014 revealed: 1. The L4-L5 disc level shows a tear of the interior annulus of the nucleus pulposus with mild

dehiscence of the nucleus pulposus with a 3 mm bulge of the nucleus pulposus with a small tear of the annulus of the inferior nucleus pulposus. Mild compromise of the AP sagittal diameter of the lumbosacral canal exacerbated by bilateral thickening of the ligamentum flavum and thickening of the posterior arch. Mild bony hypertrophy of the articular facets. Neural foramina are patent. 2. The L-5-S1 disc level shows a tear of the interior annulus of the nucleus pulposus with mild dehiscence of the nucleus pulposus with a 5 mm bulge of the nucleus pulposus with a small tear of the annulus of the inferior nucleus pulposus. Mild compromise of the AP sagittal diameter of the lumbosacral canal exacerbated by bilateral thickening of the ligamentum flavum and thickening of the posterior arch. Mild bony hypertrophy of the articular facets. Neural foramina are patent.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV Bilateral Lower Extremities: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Electrodiagnostic Studies, EMGs, NCVs

Decision rationale: Pursuant to the California Chronic Medical Treatment and Official Disability Guidelines, EMG/ nerve conduction velocity studies of the lower extremities are not medically necessary. The guidelines state electrodiagnostic studies are not recommended for low back conditions. NCVs are not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. EMGs, however, are recommended as an option and may be useful to obtain unequivocal evidence of radiculopathy, after one month of conservative therapy but the EMGs are not necessary if radiculopathy is already clinically obvious. In this case, there are two documents for review. One is a handwritten, largely illegible initial consultation dated July 28, 2014. The diagnosis is lumbar radiculopathy. However, there is no physical examination/neurologic findings documenting the presence of the radiculopathy. The second follow-up note was dated July 23, 2014 (five days prior to the initial examination). The diagnosis on the second note was lumbar sprain and right knee sprain. There is no clear evidence presented in the record of significant neurologic deficit, most notably radiculopathy. Additionally there is no specific justification or rationale for the requested nerve conduction study and EMG. Consequently, the NCV/EMG of the lower extremities is not medically necessary. Based on the clinical findings in the medical record and the peer reviewed, evidence based guidelines, the NCV/EMG is not medically necessary.