MAXIMUS Federal Services

Case Number:	CM14-0153166		
Date Assigned:	09/23/2014	Date of Injury:	12/10/2004
Decision Date:	10/29/2014	UR Denial Date:	08/25/2014
Priority:	Standard	Application Received:	09/19/2014

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 Alabama. 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 patient is a 62 year old female who was injured on 12/10/2004 when she tripped and fell. Prior medication history included Protonix, Lyrica, Vicodin, Norco, and Lidoderm patch. Pain management note dated 07/16/2014 states the patient presented with complaints of low back pain, buttock and leg pain. She reported knee pain as well and rated her pain as a 7/10 and it worsens with activities. On exam, there is tenderness to palpation over the midline at L3-S1 diffusely and PSIS buttock tenderness bilaterally. The thoracolumbar paraspinal muscles revealed diffuse tenderness with tightness from T9 down to L2 level. Motor exam was limited by pain and effort revealing hip flexion on the right at -5/5; knee extension at 4/5 on the right and 3/5 on the left; ankle dorsiflexion is 3/5 bilaterally; ankle plantar flexion is 3/5 bilaterally and EHL is 3/5 bilaterally. The patient was diagnosed with chronic pain in the bilateral knees; chondromalacia of the patella, lumbar strain with probable degenerative disk disease, possible fibromyalgia, myofascial pain over the thoracolumbar region and increasing left leg weakness and left thigh atrophy. She was recommended for an EMG and nerve conduction study of the lower extremities to evaluate leg weakness and atrophy.Prior utilization review dated 08/25/2014 states the request for EMG Study Bilateral Lower Extremities; NCV Study Bilateral Lower Extremities is not certified based on the evidence submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG Study Bilateral Lower Extremities: Overturned

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 and leg, EMG (Electromyography)

Decision rationale: The above ODG guidelines regarding electromyography states "Recommended (needle, not surface) as an option in selected cases... EMGs may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy... EMG findings may not be predictive of surgical outcome in cervical surgery, and patients may still benefit from surgery even in the absence of EMG findings of nerve root impingement. This is in stark contrast to the lumbar spine where EMG findings have been shown to be highly correlative with symptoms." It also states "Indications when particularly helpful: EMG may be helpful for patients with double crush phenomenon, in particular, when there is evidence of possible metabolic pathology such as neuropathy secondary to diabetes or thyroid disease." In this case, note from 7/16/14 demonstrates that the patient has tried conservative therapy including "medications" and "acupuncture." In addition, the physical exam is not clear on a diagnosis of radiculopathy and "double crush" phenomenon including diabetic neuropathy may be considered based on exam findings of bilateral feet/leg "thick sensation." Therefore, based on the above guidelines and criteria as well as the clinical documentation stated above, the request is medically necessary.

NCV Study Bilateral Lower Extremities: Overturned

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 and leg, NCS (Nerve conduction study)

Decision rationale: The above ODG guidelines for nerve conduction studies states "but recommended if the EMG is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely based on the clinical exam. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy." Again in this case, note from 7/16/14 does not document physical examination findings that are cleary radiculopathy, including a difference in thigh but not calf circumferences, "thick sensation" on sensory exam of b/l legs and feet. With bilateral lower extremity findings, a metabolic neuropathy can be considered, and NCS can help to rule that out. Therefore, based on the above guidelines and criteria as well as the clinical documentation stated above, the request is medically necessary.