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| <b>Case Number:</b>   | CM14-0171143 |                              |            |
| <b>Date Assigned:</b> | 10/23/2014   | <b>Date of Injury:</b>       | 02/01/2008 |
| <b>Decision Date:</b> | 11/21/2014   | <b>UR Denial Date:</b>       | 09/30/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 10/16/2014 |

### 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 Family Medicine and is licensed to practice in Florida. 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 53-year-old male who was injured on 2/01/2008 after falling into a ditch. He underwent an ORIF of a left tibial plateau fracture on 2/05/2008. On 9/9/2008 he had a reconstruction of the left anterior cruciate ligament and lateral collateral ligament. On 11/07/2008 he underwent closed manipulation arthroscopic debridement of the left knee. On 4/9/2009 he underwent reconstruction of the posteriofibular and fibular collateral ligament. On 10/6/2009 he underwent left knee lateral collateral ligament reconstruction. On 2/14/2011 he underwent left peritoneal nerve decompression. On 7/6/2011 he had a repeat arthroscopic left knee debridement. On 9/20/2013 he underwent a total left knee replacement. He has had left calf paresthesias since his left tibia ORIF surgery. This patient has also received the following additional treatment modalities: lumbar epidural steroid injection, physical therapy treatment, and medications. On 1/13/2014 he had an EMG study performed on the LLE, which showed findings indicative of a chronic L5/S1 nerve radiculopathy without definite signs of active nerve denervation. Decreased conduction velocity of the left peritoneal nerve was also seen. A 2/2014 Lumbar MRI showed a left ward disc bulge and moderate neuroforaminal stenosis. A Neurologist evaluated him on 08/4/2014 for his left lower extremity paresthesia complaints. This Neurology consultant felt that the patient's left lower extremity paresthesias were secondary to a "left peritoneal neuropathy of mild severity as well as signs of left peritoneal neuritis. Electrodiagnostic studies may be repeated to further assess the presence of any lumbosacral radiculopathy." Physical exam records from this office visit fail to reveal any significant neurologic findings in the right lower extremity. No signs of motor weakness were found on his exam in either extremity. Records indicate that this patient is currently on temporary total disability. A utilization review physician did not certify the requested EMG. Likewise, an

independent medical review regarding the medical necessity of an EMG on the right lower extremity has been requested.

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

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

**EMG/NCV (electrodiagnostic study) of the right lower extremity:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Special Studies and Diagnostic and Treatment Considerations Page(s): 360-363.

**Decision rationale:** In accordance with California MTUS guidelines, EMG studies "may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks." These guidelines are also clear that electrodiagnostic studies should be considered after a detailed neurologic exam. This patient's provided medical records do not indicate that he has evidence of focal neurologic dysfunction in the right lower extremity. His complaint is numbness in the calf of the left lateral extremity. A neurologic exam consultant note from 8/4/2014 did not note any neurologic abnormalities in the right lower extremity. This Neurologist felt that the patient's left lower extremity paresthesias were secondary to a "left peritoneal neuropathy of mild severity as well as signs of left peritoneal neuritis. Electrodiagnostic studies may be repeated to further assess the presence of any lumbosacral radiculopathy." This consultant recommended a bilateral EMG study, despite the fact that the patient's symptoms are well localized to the left lower extremity. No explanation was provided as to why a right lower extremity EMG study is also considered necessary in the presence of a normal right lower extremity neurologic exam. Likewise, this request for a right lower extremity EMG study is considered not medically necessary.