

Case Number:	CM14-0067966		
Date Assigned:	07/11/2014	Date of Injury:	09/10/2010
Decision Date:	12/31/2014	UR Denial Date:	04/29/2014
Priority:	Standard	Application Received:	05/12/2014

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 Internal 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:

The patient is an injured worker with a history of low back and left knee injuries. Date of injury was 09-10-2010. Mechanism of injury was fall, resulting in left knee and low back injuries. The progress report dated 10/22/13 documented lumbar sprain and strain and left knee strain diagnoses. The initial qualified medical evaluator report dated January 27, 2014 documented that magnetic resonance imaging (MRI) was reviewed on June 16, 2013. Lumbar MRI magnetic resonance imaging demonstrated T12-L1, L1-L2, L2-L3, L3-L4, L4-L5, and L5-S1 were unremarkable. The MRI assessment was right lateral scoliosis and unremarkable exiting nerve roots at all lumbar spine levels. MRI magnetic resonance imaging of the left knee revealed a torn meniscus. Physical examination performed 1/27/14 demonstrated 4/5 muscle strength in the left hip abductors, knee extensors, and ankle dorsiflexors. Left ankle plantar flexors, ankle invertors, and toe extensors demonstrated 5/5 muscle strength. The right lower extremity had 5/5 muscle strength. The patient entered and exited the examination room absent any hand held assistive device. Gait exhibited equal and symmetrical weight bearing on both lower extremities. Cadence was normal with normal progression of weight bearing from heel-strike through foot-flat to toe push-off. Speed of movement when exiting the room was normal. Sensation was intact in the lower extremities. Lumbar flexion was 60 degrees. Diagnoses were left hip contusion with consequent myofascial pain syndrome involving the left sacroiliac joint, left piriformis muscle, left psoas tendon insertion, left hip bursa, left tensor fascia latae, causing left sciatica symptoms into the left leg radiating to the calf. Electromyography and nerve conduction studies of the lower extremities were requested on 4/23/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electromyography of the Lower Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305, 308-309.

Decision rationale: California Medical Treatment Utilization Schedule (MTUS) addresses electromyography (EMG). American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 12 Low Back Complaints state that Electromyography (EMG) for clinically obvious radiculopathy is not recommended. EMG is recommended to clarify nerve root dysfunction. ACOEM 3rd Edition states that electrodiagnostic studies, which include needle EMG, are recommended where a computed tomography (CT) or magnetic resonance imaging (MRI) is equivocal and there are ongoing pain complaints that raise questions about whether there may be a neurological compromise that may be identifiable (i.e., leg symptoms consistent with radiculopathy, spinal stenosis, peripheral neuropathy, etc.). Electrodiagnostic studies for patients with acute, subacute, or chronic back pain who do not have significant leg pain or numbness are not recommended. Medical records documented an unremarkable lumbar MRI. The initial qualified medical evaluator report dated January 27, 2014 documented that MRI magnetic resonance imaging was reviewed on June 16, 2013. Lumbar MRI magnetic resonance imaging demonstrated T12-L1, L1-L2, L2-L3, L3-L4, L4-L5, and L5-S1 were unremarkable. The MRI assessment was right lateral scoliosis and unremarkable exiting nerve roots at all lumbar spine levels. There was no indication that the lumbar MRI was equivocal. MRI magnetic resonance imaging of the left knee revealed a torn meniscus. Diagnoses were left hip contusion with consequent myofascial pain syndrome involving the left sacroiliac joint, left piriformis muscle, left psoas tendon insertion, left hip bursa, left tensor fasciae latae, causing left sciatica symptoms into the left leg radiating to the calf. The medical report dated 1/27/14 was the latest report present in the submitted medical records. Progress reports do not provide a rationale for the EMG. Given the unremarkable lumbar MRI, electromyography (EMG) is not supported. Therefore, the request for Electromyography of the lower extremities is not medically necessary.

Nerve Conduction Studies of the Lower Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper 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, Lumbar & Thoracic (Acute & Chronic) Nerve conduction studies (NCS) Work Loss Data Institute. Bibliographic Source: Work Loss Data Institute. Low back -- lumbar & thoracic (acute & chronic). Encinitas (CA): Work Loss Data Institute; 2013 Dec 4.
<http://www.guideline.gov/content.aspx?id=47586>

Decision rationale: California Medical Treatment Utilization Schedule (MTUS) does not address nerve conduction studies for low back conditions. Official Disability Guidelines (ODG) Low Back, Lumbar & Thoracic (Acute & Chronic) states that nerve conduction studies (NCS) are not recommended. The Work Loss Data Institute guidelines for the low back states that nerve conduction studies (NCS) are not recommended. Medical records documented an unremarkable lumbar magnetic resonance imaging (MRI). The initial qualified medical evaluator report dated January 27, 2014 documented that MRI magnetic resonance imaging was reviewed on June 16, 2013. Lumbar MRI magnetic resonance imaging demonstrated T12-L1, L1-L2, L2-L3, L3-L4, L4-L5, and L5-S1 were unremarkable. The MRI assessment was right lateral scoliosis and unremarkable exiting nerve roots at all lumbar spine levels. MRI magnetic resonance imaging of the left knee revealed a torn meniscus. Diagnoses were left hip contusion with consequent myofascial pain syndrome involving the left sacroiliac joint, left piriformis muscle, left psoas tendon insertion, left hip bursa, left tensor fascia latae, causing left sciatica symptoms into the left leg radiating to the calf. ODG and Work Loss Data Institute guidelines do not recommend nerve conduction studies. Therefore, the request for Nerve conduction studies of the lower extremities is not medically necessary.