

Case Number:	CM13-0066939		
Date Assigned:	01/03/2014	Date of Injury:	09/19/2013
Decision Date:	01/28/2015	UR Denial Date:	12/11/2013
Priority:	Standard	Application Received:	12/17/2013

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 Practice and is licensed to practice in North Carolina. 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 52-year-old with a reported date of injury of 09/19/2013. The patient has the diagnoses of lumbosacral strain/sprain, shoulder sprain/strain and knee sprain /strain. The injury occurred as a result of carrying a 60 pound box of meat at work. Per the initial evaluation dated 10/24/2013, the patient had complaints of low back, left knee and left shoulder pain. The physical exam noted tenderness at the medial joint line of the left knee with a positive McMurray sign. The lumbar spine showed tenderness on the paravertebral muscles with decreased range of motion. The left shoulder exam noted pain with range of motion and tenderness in the subacromial region and positive Hawkin's, Apley's, Yergason's and Speed's test. Treatment plan recommendations included chiropractic care, x-rays, oral medications and topical analgesics. Per the most recent progress notes provided for review dated 03/13/2014, the patient continued to have low back pain with prominent left lower extremity tingling and numbness. The physical exam simply noted tenderness to palpation. The treatment plan recommendations included continued TENs unit and ice/heat therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electromyography (EMG) of the Lower Extremities: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304.

Decision rationale: The ACOEM section on low back complaints and special diagnostic studies states: Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures). Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. The provided documentation makes no mention of any sensory or neurologic deficits in the lower extremity physical exam on the initial physical exam dated 10/13. It states there were no neurologic deficits. The patient does have pain radiating to the lower extremity per the most recent progress notes but no evidence of neurologic dysfunction on physical exam. Therefore, this request is not medically necessary.

Nerve Conduction Velocity (NCV) of the Lower Extremities: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304.

Decision rationale: The ACOEM section on low back complaints and special diagnostic studies states: Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures). Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. The provided documentation makes no mention of any sensory or neurologic deficits in the lower extremity physical exam on the initial physical exam dated 10/13. It states there were no neurologic deficits. The patient does have pain radiating to the lower extremity per the most recent progress notes but no evidence of neurologic dysfunction on physical exam. Therefore, this request is not medically necessary.

