

Case Number:	CM15-0102999		
Date Assigned:	06/05/2015	Date of Injury:	09/12/2011
Decision Date:	07/03/2015	UR Denial Date:	04/29/2015
Priority:	Standard	Application Received:	05/28/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: North Carolina

Certification(s)/Specialty: Family Practice

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 is a 50 year old female who sustained an industrial injury on 9/12/11 from a slip and fall involving her neck, shoulders, and bilateral upper extremities including her arms, elbows and hands as well as her low back. She felt immediate pain in the above mentioned areas as well as her right ankle. She was medically evaluated the following day and given pain medication, x-rays and was temporarily totally disabled. She had MRI's of the lumbar, cervical, thoracic spines and bilateral knees. She had right knee surgery (11/2012) and physical therapy followed. She currently complains of frequent headaches and moderate neck pain and stiffness; improved right shoulder pain and unimproved left shoulder pain with pain radiating to the arms and elbows, she has popping, clicking, grinding sensations in the left shoulder; she continues with left elbow pain without radiation; bilateral hand and wrists pain and numbness has improved; the thoracic spine exhibits ongoing, constant pain in the upper and mid-back with restricted range of motion; the low back has unimproved pain with radiation to the left buttock and leg and numbness and tingling in the leg, there is restricted range of motion; bilateral knees have ongoing unimproved pain, moderate to severe in the left and intermittent moderate in the right, her knee give out and there is intermittent swelling; the right foot and ankle has ongoing unimproved pain with restricted range of motion. Her basic activities of daily living can be performed independently without pain. She is restricted when activity involves lifting or strenuous activity. Diagnoses include status post bilateral knee contusions; prior left knee arthroscopy in 2009; rule out internal derangement, both wrists; lumbar spine strain; cervicothoracic spine strain; left shoulder impingement syndrome; rule out internal derangement, both knees; right ankle sprain; resolved bilateral elbow arthralgia. In the progress

note dated 4/6/14 the treating provider's plan of care includes a request for electromyography/ nerve conduction studies of the bilateral lower extremities to determine if there is a radicular component to her complaints.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG (electromyography)/NCV (nerve conduction velocity) of the bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints.

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

Decision rationale: The ACOEM chapters on low back complaints and the need for lower extremity EMG/NCV 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. There are unequivocal objective findings of nerve compromise on the neurologic exam provided for review. However there is not mention of surgical consideration. There are no unclear neurologic findings on exam. For these reasons, criteria for lower extremity EMG/NCV have not been met as set forth in the ACOEM. Therefore, the request is not medically necessary.