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| Case Number: | CM15-0108360 | | |
| Date Assigned: | 06/15/2015 | Date of Injury: | 06/11/2014 |
| Decision Date: | 07/14/2015 | UR Denial Date: | 05/21/2015 |
| Priority: | Standard | Application Received: | 06/05/2015 |

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 54 year old male, who sustained an industrial injury on 06/11/2014. Medical records provided by the treating physician did not indicate the injured worker's mechanism of injury. The injured worker was diagnosed as having osteoarthritis of the knee, general internal derangement of the knee unspecified, lumbosacral spondylosis without myelopathy, lumbar spine strain, generalized and unspecified atherosclerosis, pain in the joint at the pelvic region and thigh, diabetes mellitus type II, and hypertension. Treatment and diagnostic studies to date has included physical therapy, status post left knee surgery performed on 12/03/2014, use of H-wave machine, [REDACTED], magnetic resonance imaging of the left knee, and medication regimen. Magnetic resonance imaging of the left knee performed on 07/28/2014 was revealing for medial meniscus posterior horn and body complex tears, lateral meniscus posterior horn radial tear with probable displaced fragment above the lateral tibial spine, complete longstanding rupture of the anterior cruciate ligament (ACL), posterior cruciate ligament mucoid degeneration, and scattered areas of tri-compartmental joint space chondromalacia. In a progress note dated 04/21/2015 the treating physician reports complaints of continued pain with an examination that was revealing for limited range of motion to the lumbar spine along with satisfactory post-operative range of motion to the left knee. The treating physician requested an electromyogram with a nerve conduction study of the left knee at a 2nd level, but the documentation provided did not indicate the specific reason for the requested study.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG (electromyography)/NCS (nerve conduction study) of the left knee, 2nd level: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343.

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.