

Case Number:	CM15-0017582		
Date Assigned:	02/05/2015	Date of Injury:	04/17/2012
Decision Date:	08/03/2015	UR Denial Date:	01/05/2015
Priority:	Standard	Application Received:	01/29/2015

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: California, Indiana, New York
Certification(s)/Specialty: Internal Medicine

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 43 year old male, who sustained an industrial injury on 4/17/2012. Diagnoses include medial meniscus tear and lumbar radiculopathy. Treatment to date has included electrodiagnostic testing, surgical intervention (left knee 5/21/2013), postoperative physical therapy and specialist consultations. Per the Comprehensive Orthopedic Reevaluation and Report dated 12/16/2014 the injured worker reported mid back pain with radiation to the left buttock. He states that he has fallen several times because of his back pain and his left leg giving way. Physical examination of the back revealed moderate tenderness without spasm at L5. Supine straight leg raise was positive on the right at 45 degrees with pain and left at 40 degrees with pain. Range of motion of the lumbar spine was restricted in all planes with pain. Left knee examination revealed arthroscopic scars and generalized swelling. There was patellar crepitus and retro patellar tenderness noted with firm palpation. There was medial and lateral joint line tenderness. McMurray's test caused pain. The plan of care included electrodiagnostic testing and follow-up care. Per the injured worker, recent electrodiagnostic testing was not properly performed. Authorization was requested for repeat EMG (electromyography)/NCV (nerve conduction studies) of the bilateral lower extremities, left knee and lumbar spine and gastroenterologist and psychiatric follow-up visits.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV of the bilateral lower extremities: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back section, EMG/NCV.

Decision rationale: Pursuant to the Official Disability Guidelines, bilateral lower extremities EMG/NCV are not medically necessary. Nerve conduction studies are not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. EMGs may be useful to obtain unequivocal evidence of radiculopathy, after one month conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious. The ACOEM states unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging if symptoms persist. In this case, the injured worker's working diagnoses are medial meniscal tear; and lumbar radiculopathy. The injured worker underwent left knee arthroscopy May 21, 2013. The date of injury is April 17, 2012. The request for authorization is December 29, 2014. According to a progress note dated December 16, 2014, the injured worker was discharged from the treating provider August 26, 2014. The injured worker returned with low back pain that radiated to the lower extremity associated with weakness and paresthesia. Objectively, there was moderate tenderness at L5, negative straight leg raising with a normal sensory and normal motor examination. The documentation by the treating provider indicates the injured worker had an EMG done recently. There was no specific date and no hard copy of the electro diagnostic study. The injured worker felt the electro diagnostic study was not performed correctly and would like it repeated. As noted above, there is no objective documentation of radiculopathy on physical examination. There is no clinical rationale or clinical indication for repeating the electro diagnostic studies without first reviewing a hard copy of the recently performed electro diagnostic study. Consequently, absent clinical documentation of the recently performed electro diagnostic studies and an unremarkable neurologic evaluation with no objective evidence of radiculopathy, bilateral lower extremities EMG/NCV are not medically necessary.

Gastroenterologist follow up visit: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Office visits.

Decision rationale: Pursuant to the Official Disability Guidelines (ODG), gastroenterologist follow-up visit is not medically necessary. The need for a clinical office visit with a healthcare

provider is individualized based upon a review of patient concerns, signs and symptoms, clinical stability and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines as opiates or certain antibiotics require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. Determination of necessity for an office visit requires individual case review and reassessment being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self-care as soon as clinically feasible. In this case, the injured worker's working diagnoses are medial meniscal tear; and lumbar radiculopathy. The injured worker underwent left knee arthroscopy May 21, 2013. The date of injury is April 17, 2012. The request for authorization is December 29, 2014. According to a progress note dated December 16, 2014, the injured worker was discharged from the treating provider August 26, 2014. The injured worker returned with low back pain that radiated to the lower extremity associated with weakness and falling. Objectively, there was moderate tenderness at L5, negative straight leg raising with a normal sensory and normal motor examination. The progress of documentation indicates the injured worker developed G.I. bleeding as a result of medication prescribed by the psychiatrist. There are no medications listed in the medical record. The likely offending medication is not present in the medical record. There are no gastrointestinal consultation notes present in the medical record. The treatment plan does not contain a clinical rationale for a follow-up GI office visit. Consequently, absent clinical documentation with prior gastroenterology progress notes and a clinical indication and rationale for a follow-up visit, gastroenterologist follow-up visit is not medically necessary.

Psychiatric follow up visit: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Office visits.

Decision rationale: Pursuant to the Official Disability Guidelines (ODG), psychiatric follow-up visit is not medically necessary. The need for a clinical office visit with a healthcare provider is individualized based upon a review of patient concerns, signs and symptoms, clinical stability and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines as opiates or certain antibiotics require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. Determination of necessity for an office visit requires individual case review and reassessment being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self-care as soon as clinically feasible. In this case, the injured worker's working diagnoses are medial meniscal tear; and lumbar radiculopathy. The injured worker underwent left knee arthroscopy May 21, 2013. The date of injury is April 17, 2012. The request for authorization is December 29, 2014. According to a progress note dated December 16, 2014, the injured worker was discharged from the treating provider August 26, 2014. The injured worker returned with low back pain that radiated to the

lower extremity associated with weakness and falling. Objectively, there was moderate tenderness at L5, negative straight leg raising with a normal sensory and normal motor examination. The progress note dated December 16, 2014 does not contain a clinical discussion of the symptoms and signs treated by the psychiatrist. There is no clinical discussion, clinical indication or rationale in the medical record for a psychiatric follow-up. As noted above, there are no medications listed in the medical record. Consequently, absent clinical documentation with a clinical discussion, indication and or rationale for psychiatric follow-up, psychiatric follow-up visit is not medically necessary.