MAXIMUS Federal Services

Case Number:	CM15-0144495		
Date Assigned:	08/05/2015	Date of Injury:	05/11/2015
Decision Date:	09/02/2015	UR Denial Date:	07/08/2015
Priority:	Standard	Application Received:	07/27/2015

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 41 year old female, who sustained an industrial injury on 05-11-2015. She has reported injury to the neck, bilateral wrists, left shoulder, bilateral knees, and low back. The diagnoses have included cervical sprain-strain; cervical spine myofasciitis and facet-induced versus discogenic pain; left shoulder sprain-strain; left elbow contusion; left knee contusion; thoracic sprain-strain; thoracic spine myofasciitis and facet-induced versus discogenic pain; lumbosacral sprain; lumbar radiculitis, sciatica; myalgia; and plantar fasciitis. Treatment to date has included medications, diagnostics, and bracing. Medications have included Ibuprofen. A progress note from the treating physician, dated 06-03-2015, documented a follow-up visit with the injured worker. The injured worker reported continuous moderate pain in the neck, at times becoming sharp and stabbing pain; she notes tingling and burning sensations in the left side of the neck; the pain radiates down into the arm and hand and down into the shoulder blades; muscle spasm and frequent headaches; continuous sharp aching pain in the shoulders, with pain radiating to the arms; she has numbness and tingling in the shoulders, arms and hands; continuous aching pain in the elbows; the pain radiates up to the neck and down the arms and hands; aching pain in the bilateral wrists, hands and fingers; there is numbness and tingling in both hands and fingers; pain in the upper and mid back continuously; the pain radiates into her shoulder blades and upper back; there is numbness and tingling and muscle spasms; continuous dull aching pain in the lower back; the pain radiates down her buttocks and back of the thighs to the feet; there is numbness and tingling in the feet; she has muscle spasms; continuous dull aching pain in the both knees; there is popping and clicking in the knees and episodes of

buckling; the pain radiates down into the calves; swelling of the knees; and she has difficulty with activities of daily living. Objective findings included palpable tenderness of the bilateral cervical paravertebral musculature and bilateral upper trapezius musculature; positive bilateral cervical compression test an bilateral shoulder depression test; ranges of motion of the cervical spine are decreased with pain; palpable tenderness of the left supraspinatus, left subacromial bursa, left subdeltoid bursa, left acromioclavicular joint; positive left apprehension and speeds tests; ranges of motion of the left shoulder are decreased with pain; palpable tenderness is present over the bilateral lateral and bilateral medial epicondyles; palpable tenderness is present over the bilateral volar and dorsal crease of the wrist; palpable tenderness over the bilateral thoracic and lumbar paravertebral musculature; Kemp's test is positive; palpable tenderness is present over the bilateral sacroiliac joints and sciatic notches; and lumbar spine ranges of motion are decreased with pain. The treatment plan has included the request for EMG (electromyography)/NCS (nerve conduction study) bilateral lower extremity.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCS bilateral lower extremity: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

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. The provided medical records and neurologic findings on exam meet criteria per the ACOEM for EMG/NCV and therefore the request is medically necessary.