

<b>Case Number:</b>	CM15-0183340		
<b>Date Assigned:</b>	09/24/2015	<b>Date of Injury:</b>	07/18/2015
<b>Decision Date:</b>	10/30/2015	<b>UR Denial Date:</b>	08/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/17/2015

### 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 32 year old male who sustained an industrial injury on 7-18-15. A review of the medical records indicates he is undergoing treatment for ACL tear, remote avulsion of the PCL, and lateral meniscus tear of the left knee. Medical records (7-27-15 to 8-4-15) indicate complaints of left knee pain with instability, "popping", stiffness, and "marked difficulty" in his ability to walk. The physical exam of the left knee (8-4-15) reveals increased pain during the exam. The treating provider indicates that the examination was "limited" due to the injured worker's "pain and degree of discomfort". The treating provider indicates "light touch elicits a significant amount of discomfort". Range of motion is noted from 0-90 degrees. "Diffuse" tenderness is noted at the medial and lateral joint line. The provider states that "further ligamentous testing could not be assessed due to the patient's degree of discomfort". Limited range of motion was also noted of the ankle. Diagnostic studies include x-rays of the left knee and an MRI of the left knee. Treatment has included physical therapy and pain medications. A request for authorization for EMG-NCV of the left leg was made. The utilization review (8-19-15) indicates denial of a request for EMG-NCV of bilateral lower extremities. The rationale states "the medical records provided did not document subjective complaints to the objective findings on neurological nature that would support the need for an electrodiagnostic study".

### 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 extremity:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

**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.