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| Case Number: | CM15-0184740 | | |
| Date Assigned: | 09/25/2015 | Date of Injury: | 03/30/2011 |
| Decision Date: | 11/02/2015 | UR Denial Date: | 09/16/2015 |
| Priority: | Standard | Application Received: | 09/21/2015 |

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: Texas, Florida, California

Certification(s)/Specialty: Preventive Medicine, Occupational 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:

This is a 42 year old female whose date of injury was March 30, 2011. Medical documentation on 9-10-15 indicated the injured worker was treated for lumbosacral spondylosis without myelopathy, lumbar muscle strain, chronic low back pain and lumbar radiculopathy. She reported continued left posterior knee pain since February 2015 without any known left knee trauma. A left knee ultrasound on 3-19-2015 was negative. She had an orthopedic surgical evaluation with the clinical impression that her left lateral thigh-calf pain was related to her lumbosacral spine. She was given a cortisone injection to the left knee with no improvement. Objective findings included tenderness to palpation to the bilateral lumbosacral area with evidence of spasm. Her low back range of motion was flexion to 45 degrees, extension to 20 degrees, and bilateral side bend to 20 degrees. She had a negative straight leg raise in the seated position to 80 degrees bilaterally without back pain. She had a positive left supine straight leg raise at 70 degrees with pain, numbness and tingling to the left lateral thigh and calf and increased left posterior knee pain. Her medications included Naproxen 500 mg and Skelaxin 800 mg, which were helpful. Chiropractic therapy had resolved her low back pain flare-ups and a nerve ablation 1-16-14 relieved her low back pain by 70-80%. Lumbar spine x-rays on 7-2-15 were interpreted by the evaluating physician as revealing no acute fracture, normal anatomic alignment and no significant spondylolisthesis of the lumbar spine with flexion or extension. There was moderate narrowing of the L5-S1 and L1-S2 disc spaces and mild facet hypertrophy of L4-5 and L5-S1. A request for authorization for a nerve conduction study and electromyogram of the left lower extremity was received on 9-10-15. On 9-16-15, the Utilization Review physician determined nerve conduction study and electromyogram of the left lower extremity was not medically necessary based on CA MTUS Chronic Pain Medical Treatment Guidelines and Official Disability Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

NCS/EMG of the left lower extremity: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter.

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

Decision rationale: The claimant was injured in 2011 with low back and left posterior knee pain since February. Knee ultrasound was negative; steroid injection gave no improvement. Straight leg raise was negative. X-rays were normal. Nerve ablation relieved pain. MRI showed degenerative changes. There were no definitive or equivocal signs on physical showing suggestions of neural damage. The MTUS ACOEM notes that electrodiagnostic studies may be used when the neurologic examination is unclear, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. In this case, there was not a neurologic exam showing equivocal or definitive signs that might warrant clarification with electrodiagnostic testing. Also, although there is degenerative change on the MRI, there is no evidence of an injury source for radicular signs or symptoms. The request is not medically necessary.