Case Number:	CM15-0201938		
Date Assigned:	10/16/2015	**Date of Injury:**	05/11/2015
Decision Date:	12/04/2015	**UR Denial Date:**	10/05/2015
Priority:	Standard	**Application Received:**	10/14/2015

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, District of Columbia, Maryland
Certification(s)/Specialty: Anesthesiology, Pain Management

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 25 year old male who sustained an industrial injury May 11, 2015, after working on a generator and feeling pain to his right leg with tingling and left hand with loss of consciousness and found in the supine position. Diagnoses were documented as high voltage electrical injury, altered mental status. A CT of the brain without contrast was documented as negative for acute cranial abnormality. Three views of the right knee revealed no fracture or dislocation. CT of the cervical spine revealed no acute cervical fracture. X-ray of the left hand 3view revealed no fracture-dislocation; no foreign body. Treatment plan included pain medication, and referrals to an orthopedic physician and neurologist. According to a primary treating physician's progress report dated October 2, 2015, the injured worker presented with complaints of bilateral hand numbness, shooting pain in the right leg with intermittent numbness. Physical examination revealed; ambulation with a cane; limited range of motion of the right knee, in brace, bend to approximately 110 degrees, decreased effusion from previous exam, negative anterior drawers, no cyanosis or edema; sensation is documented as abnormal, coordination and cerebellum; no tremor. Diagnoses are knee pain; neuropathy. Treatment plan included to continue with gabapentin and at issue, a request for authorization for an EMG (electromyography) of the lower extremity. An MRI of the right knee dated May 12, 2015 (report present in the medical record) impression; high grade sprain medial patellar retinaculum; tear of the medial collateral ligament at its tibial attachment; mild sprain fibular collateral ligament; bone contusion posterior lateral femoral condyle; bone contusion lateral tibial plateau, no depression lateral tibial plateau. According to utilization review dated October 5, 2015, the request for EMG referral is non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG referral: Overturned

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: ACOEM guidelines support ordering of imaging studies for emergence of red flags, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. Per MTUS ACOEM p182, with regard to the detection of neurologic abnormalities, EMG for diagnosis of nerve root involvement if findings of history, physical exam, and imaging study are consistent, is not recommended. The documentation submitted for review contains evidence of neurologic dysfunction. Per progress report dated 10/2/15, the injured worker complained of bilateral hand numbness, shooting pain in the right leg with intermittent numbness. Sensation was documented as abnormal. I respectfully disagree with the UR physician's assertion that there were no signs of neurologic dysfunction to investigate with EMG. The request is medically necessary.