

Case Number:	CM15-0081796		
Date Assigned:	05/04/2015	Date of Injury:	05/13/2014
Decision Date:	06/10/2015	UR Denial Date:	03/31/2015
Priority:	Standard	Application Received:	04/28/2015

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

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 50 year old female who sustained a work related injury May 13, 2014. While folding sheets, they became caught in her legs and she fell, landing on her buttocks on cement. She had pain in her knees, back, shoulder, and hip. She was treated with medication, a brace (unspecified), and acupuncture for diagnoses of knee strain; lumbar strain; injury to coccyx; cervical strain; shoulder strain and bilateral hip strain. According to an orthopedic qualified medical evaluation, dated February 19, 2015, the injured worker presented with continued, back pain, bilateral hip pain with cracking, shoulder pain with cracking, worse on the left, knee pain, worse on the left, and stiffness and tightness of the neck. She uses a cane for ambulation, limps slightly on the left, and wears a left knee brace. Diagnostic impression included cervical strain with disc bulging; lumbar strain with minimal bulging; left shoulder tendinitis; suspect trochanter bursitis of the hips; bilateral knee derangement, worse on the left with patellofemoral symptoms. At issue, is the request for authorization of Electromyography / Nerve Conduction Velocity (EMG/NCV) of the bilateral upper and lower extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electromyography/Nerve Conduction Velocity (EMG/NCV) of the Bilateral Lower Extremities: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

Decision rationale: Based on the 02/19/15 QME report provided by treating physician, the patient presents with pain to back, hips and bilateral knees, worse on the left. The request is for Electromyography/ Nerve Conduction Velocity (EMG/NCV) of the Bilateral Lower Extremities. RFA not provided. Patient's diagnosis on 02/19/15 included history of lumbar strain with minimal bulging, suspect trochanteric bursitis of hips, and bilateral knee derangement, worse on the left with patellofemoral symptoms. The patient uses a cane for ambulation, limps slightly on the left, and wears a left knee brace. Treatment to date included imaging studies and medications. Patient medications include Naprosyn, Tramadol and Omeprazole. The patient is temporarily partially disabled, per QME report dated 02/19/15. Treatment reports were provided from 06/27/14 - 02/19/15. For EMG, ACOEM Guidelines page 303 states "Electromyography, including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks." Regarding Nerve conduction studies, ODG guidelines Low Back Chapter, under Nerve conduction studies states, "Not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy." ODG for Electrodiagnostic studies (EDS) states, "(NCS) which are not recommended for low back conditions and EMGs (Electromyography) which are recommended as an option for low back." Progress report with the request or medical rationale was provided. UR letter dated 03/31/15 denied the request quoting guidelines. In this case, the patient ambulates with a cane and continues with complaints of back pain and lower extremity components which include the bilateral knees. Physical examination to the lumbar spine on 02/19/15 revealed tenderness to right lumbar and sacroiliac joint area. Range of motion was decreased, especially on extension and bilateral bending, 15 degrees. Examination of the left knee revealed crepitation and range of motion 0-90 degrees. Positive McMurray's test. Further diagnostic testing may be useful to obtain unequivocal evidence of radiculopathy. There is no indication that prior EMG/NCV testing has been performed. Therefore, the request for EMG/NCV of the bilateral lower extremities is medically necessary.

Electromyography/Nerve Conduction Velocity (EMG/NCV) of the Bilateral Upper Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines: Neck & Upper Back - Electromyography (EMG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints Page(s): 260-262, 303.

Decision rationale: Based on the 02/19/15 QME report provided by treating physician, the patient presents with pain to neck and shoulder, worse on the left. The request is for Electromyography/Nerve Conduction Velocity (EMG/NCV) of the Bilateral Upper Extremities. RFA not provided. Patient's diagnosis on 02/19/15 included cervical strain with disc bulging, and left shoulder tendinitis. Physical examination to the cervical spine on 02/19/15 revealed tenderness and tightness. Range of motion slightly decreased on rotation, 70 degrees. Examination of the left shoulder revealed no tenderness to palpation. Range of motion decreased on extension, 30 degrees. Positive Impingement sign on left. Treatment to date included imaging studies and medications. Patient medications include Naprosyn, Tramadol and Omeprazole. The patient is temporarily partially disabled, per QME report dated 02/19/15. Treatment reports were provided from 06/27/14 - 02/19/15. For EMG, ACOEM Guidelines page 303 states "Electromyography, including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks." ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11, page 260-262 states: "Appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful. NCS and EMG may confirm the diagnosis of CTS but may be normal in early or mild cases of CTS. If the EDS are negative, tests may be repeated later in the course of treatment if symptoms persist." Progress report with the request or medical rationale was provided. There is no indication that prior EMG/NCV testing has been done. In this case, the patient presents with neck and shoulder pain, but there is no indication that there is pain, which radiates to the upper extremities or any other neurological deficits to the upper extremities. Physical examination findings to the cervical spine were unremarkable. NCV/EMG are generally utilized to differentiate between cervical radiculopathy and carpal tunnel syndrome, this patient does not present with complains suggestive of either condition. Given the lack of clinical evidence, the request for EMG/NCV of the bilateral upper extremities is not medically necessary.