

Case Number:	CM14-0182829		
Date Assigned:	11/07/2014	Date of Injury:	07/25/2014
Decision Date:	12/16/2014	UR Denial Date:	10/23/2014
Priority:	Standard	Application Received:	11/03/2014

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. The expert reviewer is Board Certified in Emergency Medicine, and is licensed to practice in New York. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 33-year-old female who was injured on July 25, 2014. The patient continued to experience pain in her right elbow, right forearm, right wrist, right fingers and thumb, abdomen, and lower back. Physical examination was notable for soft, non-distended abdomen, tenderness of the lumbar spine, nonspecific right hand tenderness, decreased sensation of the left leg, and decreased sensation of the right first and second fingers. Diagnoses included lumbar sprain/strain, right arm sprain/strain, right elbow sprain/strain, headache, anxiety, insomnia, and bilateral knee sprain/strain. Treatment included epidural steroid injection and medications. Requests for authorization for MRI bilateral knees, EMG/NCV of the upper extremities, and EMG/NCV of the lower extremities were submitted for consideration.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI bilateral knees: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 334-335. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, MRI's (magnetic resonance imaging)

Decision rationale: Per MTUS MRI of the knee is indicated only for meniscus tear if surgery is being considered, ligament tears of the knee for confirmation, or patellar tendinitis if surgery is being considered. Per ODG indications for MRI of the knee are as follows: - Acute trauma to the knee, including significant trauma (e.g, motor vehicle accident), or if suspect posterior knee dislocation or ligament or cartilage disruption.- Nontraumatic knee pain, child or adolescent: nonpatellofemoral symptoms. Initial anteroposterior and lateral radiographs nondiagnostic (demonstrate normal findings or a joint effusion) next study if clinically indicated. If additional study is needed.- Nontraumatic knee pain, child or adult. Patellofemoral (anterior) symptoms. Initial anteroposterior, lateral, and axial radiographs nondiagnostic (demonstrate normal findings or a joint effusion). If additional imaging is necessary, and if internal derangement is suspected.- Nontraumatic knee pain, adult. Nontrauma, nontumor, nonlocalized pain. Initial anteroposterior and lateral radiographs nondiagnostic (demonstrate normal findings or a joint effusion). If additional studies are indicated, and if internal derangement is suspected.- Nontraumatic knee pain, adult - nontrauma, nontumor, nonlocalized pain. Initial anteroposterior and lateral radiographs demonstrate evidence of internal derangement - Repeat MRIs: Post-surgical if need to assess knee cartilage repair tissue. (Routine use of MRI for follow-up of asymptomatic patients following knee arthroplasty is not recommended. In this case the documentation in the medical record states that the patient is not experiencing pain in her knees. There is no indication for MRI imaging of the knees. The request is not medically necessary.

EMG/NCV UE: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: 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. In this case, the pain in the patient's right upper extremity occurs only occasionally. In addition the patient is not experiencing symptoms of radicular pain and there are no focal motor deficits. Sensory deficit is limited to the first and second fingers of the right hand. Medical necessity has not been established. The request is not medically necessary.

EMG/NCV LE: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303, 310. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back- Thoracic and Lumbar, Nerve Conduction Studies

Decision rationale: EMG's (electromyography) are recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms. Nerve conduction studies are not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. This systematic review and meta-analysis demonstrate that neurological testing procedures have limited overall diagnostic accuracy in detecting disc herniation with suspected radiculopathy. In the management of spine trauma with radicular symptoms, EMG/nerve conduction studies (NCS) often have low combined sensitivity and specificity in confirming root injury, and there is limited evidence to support the use of often uncomfortable and costly EMG/NCS. In this case the documentation does not support the diagnosis of radiculopathy of the lower extremity. The decreased sensation of the left lower leg is not described as dermatomal. There is no indication for EMG/NCV of the lower extremities. The request is not medically necessary.