

Case Number:	CM14-0097914		
Date Assigned:	07/28/2014	Date of Injury:	04/04/2013
Decision Date:	07/20/2015	UR Denial Date:	06/16/2014
Priority:	Standard	Application Received:	06/26/2014

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. 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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, 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 55-year-old male patient who sustained an industrial injury on 04/04/2013. A recent primary treating office visit dated 04/07/2015 reported the patient with subjective complaint of having intermittent moderate left Achilles tendon pain and intermittent bilateral hip pain. In addition, he is fatigued. Objective assessment found the patient right shoulder tender to palpation about the anterolateral shoulder and supraspinatus. There is mild tenderness extending to the pectoralis and restricted range of motion secondary to pain. There is also rotator cuff weakness. The lumbar spine revealed increased tone and tenderness about the paralumbar musculature with tenderness at the mid-line thoraco-lumbar junction and over the Level of L5-S1 facets; right greater. There is muscle spasms noted. The left knee showed lateral subluxation of the patella with crepitus and guarding. The patient is found with an antalgic gait, guarding the right knee. There are weak quadriceps noted along with knots and severe tenderness near the junction. He is diagnosed with the following: right shoulder rotator cuff tendinitis/bursitis; left knee strain/sprain; status post left Achilles tendon repair; lumbar strain/sprain secondary to above, and gastritis. The patient is deemed post permanent and stationary. Back on 05/29/2014, a primary treating visit showed the patient with continued subjective complaint of intermittent moderate left ankle pain with swelling in the left foot. He also states the big toe does not have full range of motion. He is continued with intermittent bilateral knees, bilateral shoulders, low back, and left hip. There is no change in the treating diagnoses and the plan of care noted recommendation for the patient to undergo nerve conduction study, and consultation regarding abdominal complaint.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV of the Left Lower Extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Electrodiagnostic testing (EMG/NCS) and Other Medical Treatment Guidelines AANEM Recommended Policy for Electrodiagnostic Medicine.

Decision rationale: The claimant sustained a work injury in April 2013 and underwent a left Achilles tendon repair. When seen, he was having intermittent moderate left ankle pain and swelling. There was increased lumbar paraspinal muscle tone and tenderness with midline thoracolumbar junction and L5-S1 lumbar facet tenderness. There was right sciatic notch tenderness. There was left knee patellar crepitus. There was decreased knee range of motion and an antalgic gait with quadriceps weakness. There was ankle tenderness. Electro diagnostic testing (EMG/NCS) is generally accepted, well-established and widely used for localizing the source of the neurological symptoms and establishing the diagnosis of focal nerve entrapments. Criteria include that the testing be medically indicated. In this case, there is no evidence of peripheral nerve compression. There is no documented neurological examination that would support the need for obtaining left lower extremity EMG or NCS testing at the time of the request. It was not medically necessary.