

Case Number:	CM15-0170653		
Date Assigned:	09/11/2015	Date of Injury:	06/07/2015
Decision Date:	10/29/2015	UR Denial Date:	08/12/2015
Priority:	Standard	Application Received:	08/31/2015

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, 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 54 year old male with an industrial injury dated 06-07-2015. His diagnoses included shoulder impingement, medial epicondylitis, lumbar sprain-strain and internal derangement of knee. He presents on 07-07-2015 with complaints of constant stabbing pain in his shoulders, arms, elbows and bilateral wrist and hands. He also complained of intermittent pain in his entire back rated as 7 out of 10 on a bad day and goes down to 6 out of 10. He also complains of a tingling sensation. Bilateral leg pain was rated as 7 out of 10. The progress note dated 07-15-2015 noted the injured worker was having pain in left knee and toe. Sensory exam remained the same as documented below. Physical exam of the lumbar noted spasm present in the paraspinal muscles with tenderness to palpation of the paraspinal muscles. Sensory examination showed no deficit in any of the dermatomes of the lower extremities to pinprick or light touch. McMurray's sign was positive on the right and left. Prior treatment included medications and physical therapy. The request for authorization dated 07-07-2015 is for: NCV of right lower extremity, NCV of left lower extremity, EMG of right lower extremity, EMG of left lower extremity. On 08-12-2015 the request for NCV of right lower extremity, NCV of left lower extremity, EMG of right lower extremity and EMG of left lower extremity was non-certified by utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG of right lower extremity: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, and Knee Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, EMGs, Electrodiagnostic Studies.

Decision rationale: Regarding the request for EMG of the right lower extremity, ACOEM Chapter 12 states that electromyography, include H-reflex tests, may be useful to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than 3 to 4 weeks. The electromyography component of electrodiagnostic testing is in fact the primary component in detecting lumbar radiculopathy. ODG further specify that EMGs are "recommended as an option (needle, not surface). EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious." Within the documentation available for review, there are no physical examination findings supporting a diagnosis of possible nerve compromise. Neurological exam of the lower extremities have identified no sensory or motor abnormalities. Given this, the current request is not medically necessary.

EMG of left lower extremity: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, and Knee Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, EMGs, Electrodiagnostic Studies.

Decision rationale: Regarding the request for EMG of the left lower extremity, ACOEM Chapter 12 states that electromyography, include H-reflex tests, may be useful to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than 3 to 4 weeks. The electromyography component of electrodiagnostic testing is in fact the primary component in detecting lumbar radiculopathy. ODG further specify that EMGs are "recommended as an option (needle, not surface). EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious." Within the documentation available for review, there are no physical examination findings supporting a diagnosis of possible nerve compromise. Neurological exam of the lower extremities have identified no sensory or motor abnormalities. Given this, the current request is not medically necessary.

NCV of left lower extremity: Upheld

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back (updated 07/17/2015) Online Version.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, EMGs, Electrodiagnostic Studies.

Decision rationale: Regarding the request for NCV of the lower extremities, ACOEM Practice Guidelines state that unequivocal objective findings that identify specific nerve compromise on the neurologic exam are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery. When a neurologic examination is less clear however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. The guidelines further specify that electromyography may be useful to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than 3 to 4 weeks. Within the documentation available for review, there is lack of a full neurologic examination documenting abnormalities in the sensory, motor, or deep tendon reflex systems to support a diagnosis of specific nerve compromise. Additionally, if such findings are present but have not been documented, there is no documentation that the patient has failed conservative treatment directed towards these complaints. Given this, the current request is not medically necessary.

NCV of right lower extremity: Upheld

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back (updated 07/17/2015) Online Version.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, EMGs, Electrodiagnostic Studies.

Decision rationale: Regarding the request for NCV of the lower extremities, ACOEM Practice Guidelines state that unequivocal objective findings that identify specific nerve compromise on the neurologic exam are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery. When a neurologic examination is less clear however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. The guidelines further specify that electromyography may be useful to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than 3 to 4 weeks. Within the documentation available for review, there is lack of a full neurologic examination documenting abnormalities in the sensory, motor, or deep tendon reflex systems to support a diagnosis of specific nerve compromise. Additionally, if such findings are present but have not been documented, there is no documentation that the patient has failed conservative treatment directed towards these complaints. Given this, the current request is not medically necessary.