Case Number:	CM15-0172574		
Date Assigned:	10/01/2015	**Date of Injury:**	05/11/2015
Decision Date:	11/09/2015	**UR Denial Date:**	08/17/2015
Priority:	Standard	**Application Received:**	09/01/2015

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, Indiana, New York
Certification(s)/Specialty: Internal Medicine

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 on 5-11-15. The injured worker was diagnosed as having non-fatal effects of electric current; electrocution; knee, leg and ankle injury; anxiety; polyneuropathy. Treatment to date has included physical therapy; medications. Diagnostics studies included CT scan brain-negative findings (5-11-15); X-rays right knee-no fracture-disloc (5-11-15); CT cervical spine-no acute cervical fracture seen (5-11-15); X-ray left hand-no fracture-disloc or foreign body seen (5-11-15); MRI right knee positive findings (5-12-15). Currently, the PR-2 notes dated 7-21-15 indicated the injured worker was in the office for a follow-up examination of his industrial injury of electrical shock, knee complaints, numbness, neuropathy, and anxiety. Current medications are listed as gabapentin, hydrocodone 5mg-acetaminophen 325mg and hydrocodone 7.5mg-acetaminophen 325mg, Loratadine and Naprosyn. The provider documents "The patient reports muscle aches, muscle weakness, arthralgia-joint pain (medial aspect of right knee) swelling in the extremities (right knee) but reports no back pain (improved). He reports depression. He is continuing to have burning-shooting pain and radionucliepathy in bilateral upper arm, left 4th fingers and right thigh. Neuro appointment in 2 weeks. Right knee pain secondary to electrocution injury no change in pain and swelling, has been having physical therapy and needs more physical therapy, ambulation improved since last visit, now walks with cane without crutch." The physical examination is documented by the provider as: Motor strength and tone normal and normal tone. Joints, bones and muscles: no contractures, malalignment, or bony abnormalities and limited range of motion for right knee with tenderness (medial aspect of right knee over the

medial epicondyle). Gait and station walk with cane, limping right leg. Sensation abnormal; reflexes: deep tendon reflexes 2+ bilaterally throughout. Coordination and cerebellum: finger-to-nose intact. Upper extremities: grossly intact, no swelling, range of motion of shoulder, elbow, wrist and finger intact, motor strength intact: full grip strength, diminished loss of sensation in bilateral hands, impaired proprioception and graphesthesia in bilateral hands, sensation to light touch impaired, and brachial reflex intact. Right knee swelling, no bruise, tender to palpation medial aspect of right knee over the medial epicondyle, knee flex is less than 70 degrees with complaints of pain. A MRI right knee is reported on 5-12-115 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." Other radiographic studies were reported on 5-11-15 but normal findings noted under "Diagnostic studies included." A Request for Authorization is dated 9-1-15. A Utilization Review letter is dated 8-17-15 and modified the certification for 3 EMGs for upper and lower body with authorization for one EMG for the upper body only. A request for authorization has been received for 3 EMGs for upper and lower body.

IMR ISSUES, DECISIONS AND RATIONALES

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

3 Electromyographies (EMGs) for upper and lower body: Upheld

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back (Acute & Chronic): Electromyography (EMG); Nerve conduction studies (NCS) (2015); ODG, Low Back - Lumbar & Thoracic (Acute & Chronic): EMGs (electromyography); Nerve conduction studies (NCS) (2015).

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies, and Low Back Complaints 2004, Section(s): Special Studies.
Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck section, EMG/NCV, Low back section, EMG/NCV.

Decision rationale: Pursuant to the Official Disability Guidelines, 3 Electromyographies (EMGs) for upper and lower body is not medically necessary. Upper Extremity: The ACOEM states (chapter 8 page 178) unequivocal findings that identifies specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging 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. Nerve conduction studies are not recommended to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but recommended if the EMG is not clearly radiculopathy or clearly negative or to differentiate radiculopathy from other neuropathies or non-neuropathies if other diagnoses may be likely based on physical examination. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy. While cervical electrodiagnostic studies are not necessary to demonstrate his cervical radiculopathy, they have been suggested to confirm a brachial plexus

abnormality, diabetic property or some problem other than cervical radiculopathy. Lower Extremity: There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. EMGs may be useful to obtain unequivocal evidence of radiculopathy, after one-month conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious. The ACOEM states unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging if symptoms persist. In this case, the injured worker's working diagnoses are injury due to electrical exposure; injury of lateral collateral ligament of knee; anxiety; and neuropathy. Date of injury is May 11, 2015. Request for authorization is July 22, 2015. According to a July 21, 2015 progress note, the injured worker has continued burning and shooting pain and radiculopathy in the bilateral upper arm, left forefinger and right side. The worker complains of right knee pain secondary to electrocution injury with no change in pain and swelling. Ambulation has improved since last visit. The injured worker progressed from crutches to cane. Objectively, motor strength is normal in the upper and lower extremities with no contractures. The right knee has limited range of motion and tenderness to palpation over the medial aspect of the right knee over the medial condyle. Neurologically, the injured worker walks with a cane. Sensation is abnormal. There is no description of the abnormalities. The upper extremity is grossly intact normal range of motion, normal motor function and full grip strength. There is impaired proprioception and diminished loss of sensation in the bilateral hands. The ACOEM states unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging if symptoms persist. The injured worker's subjective symptoms and clinical objective findings support EMG studies of the upper extremities. However, the lower extremities appear to be free of radiculopathy with localized pain to the right knee only. There is no clinical rationale or indication for performing an EMG of the lower extremities. Based on clinical information in the medical record, peer-reviewed evidence-based guidelines and no documentation with the clinical indication or rationale for an EMG of the lower extremities, 3 Electromyographies (EMGs) for upper and lower body is not medically necessary.

18 sessions of physical therapy: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Physical therapy.

Decision rationale: Pursuant and to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, 18 sessions of physical therapy are not medically necessary. Patients should be formally assessed after a six visit clinical trial to see if the patient is moving in a positive direction, no direction or negative direction (prior to continuing with physical therapy). When treatment duration and/or number of visits exceed the guideline, exceptional factors should be noted. In this case, the injured worker's working diagnoses are injury due to electrical exposure; injury of lateral collateral ligament of knee; anxiety; and neuropathy. Date of injury is May 11, 2015. Request for authorization is July 22, 2015. According to a July 21, 2015

progress note, the injured worker has continued burning and shooting pain and radiculopathy in the bilateral upper arm, left forefinger and right side. The worker complains of right knee pain secondary to electrocution injury with no change in pain and swelling. Ambulation has improved since last visit. The injured worker progressed from crutches to cane. Objectively, motor strength is normal in the upper and lower extremities with no contractures. The right knee has limited range of motion and tenderness to palpation over the medial aspect of the right knee over the medial condyle. Neurologically, the injured worker walks with a cane. Sensation is abnormal. There is no description of the abnormalities. The upper extremity is grossly intact normal range of motion, normal motor function and full grip strength. There is impaired proprioception and diminished loss of sensation in the bilateral hands. The utilization review indicates the injured worker received 12 physical therapy sessions to date. The guidelines recommend 10 physical therapy sessions over eight weeks for treatment of myositis and radiculitis. The treating provider is requesting an additional 18 physical therapy sessions. This exceeds the recommended guidelines. The injured worker did progress from crutches to obtain (a reflection of objective functional improvement with prior physical therapy). As a result, an additional six physical therapy sessions is clinically indicated. The injured worker should be reassessed with objective functional improvement after the six additional physical therapy sessions to determine whether supplementary physical therapy sessions are clinically indicated. There are no compelling clinical facts to support an additional 18 physical therapy sessions. Based on clinical information in the medical record and the peer-reviewed evidence-based guidelines, 18 sessions of physical therapy are not medically necessary.