

Case Number:	CM15-0044094		
Date Assigned:	03/16/2015	Date of Injury:	03/01/1999
Decision Date:	05/11/2015	UR Denial Date:	03/02/2015
Priority:	Standard	Application Received:	03/09/2015

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: Emergency 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 61-year-old female who reported an injury on 03/01/1999. The mechanism of injury was a trip and fall. Her diagnoses included spondylolisthesis, unstable L4-5 with moderate to severe stenosis, generalized deconditioning and pain, history of myofascial pain syndrome, status post right total knee replacement, and left knee resulting in difficulty with ambulation. Her past treatment has included epidural steroid injections, physical therapy, work modification, acupuncture, and aquatic therapy. Her diagnostic studies have included MRIs, and x-ray. The injured worker had complaint of constant pain, stiffness, and tension in her lower back. She rated that pain at a 7/10 to 8/10. The pain was worse on the left lower back area with pain radiating to her left hip down to her foot. She felt numbness and tingling in her legs. Her surgical history included right knee arthroscopy on 07/12/1999 and again on 10/20/1999, and for the third time on 11/02/2000; left knee arthroscopy in 2012; right knee total knee replacement in 2013; and left wrist surgery in 2014. On physical exam, it was noted there was tenderness throughout the lumbar spine on palpation, maximally at the lumbosacral junction. Her range of motion was measured in forward flexion of the lumbar spine at 20 degrees, extension at 10 degrees. Straight leg raise testing was positive at 80 degrees. Faber testing was positive bilaterally. Her medications included Amitiza, Neurontin, Percocet, Soma, Flexeril, Prevacid, and Senna. Her treatment plan included requesting core strengthening and trunk stabilization program with neutral spine protocol. Aquatic pool therapy would be of benefit. Request an EMG and nerve conduction study as well as neurologic evaluation. The rationale for the request was not included in the medical records. The Request for Authorization form was signed and dated 02/13/2015 in the medical record.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG Left Lower Extremity: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The request for EMG Left Lower Extremity is not medically necessary. California MTUS/ACOEM Guidelines state that an electromyography may be useful to identify subtle, focal neurologic dysfunction in injured workers with low back symptoms lasting more than 3 or 4 weeks. There was a lack of neurological deficits pertaining to the lumbar spine documented. There was no indication of failure of conservative care treatment to include physical therapy. The request for EMG Left Lower Extremity is not medically necessary.

NCV Left Lower Extremity: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, NCV.

Decision rationale: The request for an NCV Left Lower Extremity is not medically necessary. The Official Disability guidelines state that an NCV is not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. There is no indication of failure of conservative care treatment to include physical therapy and medication management. Furthermore, the guidelines do not recommend NCV for lower extremity. As such, the request for an NCV Left Lower Extremity is not medically necessary.

EMG Right Lower Extremity: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The request for EMG Right Lower Extremity is not medically necessary. California MTUS/ACOEM Guidelines state that an electromyography may be useful to identify subtle, focal neurologic dysfunction in injured workers with low back symptoms lasting more than 3 or 4 weeks. There was a lack of neurological deficits pertaining to the lumbar spine documented. There is no indication of failure of conservative care treatment to include physical therapy. The request for EMG Right Lower Extremity is not medically necessary.

NCV Right Lower Extremity: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, NCV.

Decision rationale: The request for an NCV Left Lower Extremity is not medically necessary. The Official Disability guidelines state that an NCV is not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. There is no indication of failure of conservative care treatment to include physical therapy and medication management. Furthermore, the guidelines do not recommend NCV for lower extremity. As such, the request for an NCV Left Lower Extremity is not medically necessary.