

Case Number:	CM15-0097316		
Date Assigned:	05/28/2015	Date of Injury:	01/26/2012
Decision Date:	07/01/2015	UR Denial Date:	05/18/2015
Priority:	Standard	Application Received:	05/20/2015

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 67-year-old male with an industrial injury date of 01/26/2012. The injury is documented as occurring while he was working on the roof of a bus and his left ankle caught between parts of the roof resulting in immediate pain. According to the provider's documentation on 01/27/2015, the injured worker was diagnosed as left ankle sprain and given Ibuprofen. X-ray at that time showed soft tissue swelling laterally without fracture or dislocation with small joint effusion. His diagnoses included pain in joint involving ankle and foot, strain of tendon of foot and ankle, neuropathic pain and abnormal gait. Co morbid conditions included borderline hypercholesterolemia and hypertension. Prior treatments included Voltaren gel, crutches, boot and physical therapy. He presents on 05/09/2015 with complaints of constant left lateral dorsal foot and heel pain with numbness, burning and tingling as well. With prolonged walking and foot inversion he has nerve like pain to his lateral dorsal foot like a "lightning bolt". Physical exam revealed slight limping gait, more noticeable in right leg with decreased foot loading. Left ankle was slightly swollen. Range of motion was intact without crepitus. There was pain with pronation passively and active. Sensory perception was normal to sharp but slightly sensitive to soft touch. Tinel's test was positive. Treatment plan included EMG/NCS of left lower extremity, Pennsaid 2% lotion for anti-inflammatory function locally, continue full time - full duty and follow up in 1 month.

IMR ISSUES, DECISIONS AND RATIONALES

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

Electromyogram (EMG) of the left lower extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back section, EMG.

Decision rationale: Pursuant to the Official Disability Guidelines, left lower extremity EMG studies are not medically necessary. 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. 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 left ankle chronic strain with possible several nerve traction or compression injury; possible chronic lateral ankle ligamentous strain and pain; MRI evidence peroneal longus partial tear; pain with pronation; prolonged weight bearing; pain in joints involving ankle and foot; strain of tendon of foot and ankle; neuropathic pain; and abnormal gait. The medical record contains 22 pages in a single progress note (an initial provider report) dated May 9, 2015. Subjectively, the injured worker has left lateral dorsal foot and heel pain with numbness, burning and tingling. The back of the physical exam. The injured worker had physical therapy, medications and immobilization. Current pain is 4-9/10. Objectively, left ankle has slight swelling laterally. Range of motion passively and slowly was intact. There was no motor weakness. Sensory examination had normal perception to sharp at slightly sensitive to soft touch. There are no abnormal neurologic findings in the record. There are no objective clinical findings of radiculopathy in the medical record. There were no unequivocal specific nerve findings on examination. Consequently, absent clinical findings of radiculopathy and unequivocal specific nerve findings, left lower extremity EMG studies are not medically necessary.

Nerve conduction study (NCS) of the left lower extremity: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Nerve conduction studies (NCS).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back section, NCS.

Decision rationale: Pursuant to the Official Disability Guidelines, left lower extremity NCS is not medically necessary. 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. 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 left ankle chronic strain with possible several nerve traction or compression injury; possible chronic lateral ankle ligamentous strain and pain; MRI evidence peroneal longus partial tear; pain with pronation; prolonged weight bearing; pain in joints involving ankle and foot; strain of tendon of foot and ankle; neuropathic pain; and abnormal gait. The medical record contains 22 pages in a single progress note (an initial provider report) dated May 9, 2015. Subjectively, the injured worker has left lateral dorsal foot and heel pain with numbness, burning and tingling. The back of the physical exam. The injured worker had physical therapy, medications and immobilization. Current pain is 4-9/10. Objectively, left ankle has slight swelling laterally. Range of motion passively and slowly was intact. There was no motor weakness. Sensory examination had normal perception to sharp at slightly sensitive to soft touch. There are no abnormal neurologic findings in the record. There are no objective clinical findings of radiculopathy in the medical record. There were no unequivocal specific nerve findings on examination. Consequently, absent clinical findings of radiculopathy and unequivocal specific nerve findings, left lower extremity NCS studies are not medically necessary.