

<b>Case Number:</b>	CM13-0071425		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	06/12/2008
<b>Decision Date:</b>	07/07/2014	<b>UR Denial Date:</b>	11/27/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/27/2013

### 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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 applicant is a represented [REDACTED] employee who has filed a claim for chronic low back, knee, neck, mid back, and upper extremity pain reportedly associated with an industrial injury of June 12, 2008. Thus far, the applicant has been treated with the following: Analgesic medications; attorney representation; transfer of care to and from various providers in various specialties; electrodiagnostic testing of the bilateral upper and bilateral lower extremities of October 24, 2013, notable for mild carpal tunnel syndrome with no evidence of a lumbar or cervical radiculopathy; transfer of care to and from various providers in various specialties; and extensive periods of time off of work, on total temporary disability. In a Utilization Review Report dated November 27, 2013, the claims administrator denied a pain management consultation, denied an MRI of the left shoulder, denied an MRI of the left knee, denied an orthopedic surgery consultation, denied electrodiagnostic testing of the upper and lower extremities, approved a follow-up visit, and retrospectively denied x-rays of the hip, knee, shoulder taken in the office setting. The claims administrator, in many cases, cited non-MTUS Guidelines, including non-MTUS Chapter 7 Guidelines, non-ODG Shoulder X-Ray Guidelines and non-MTUS Third Edition ACOEM Guidelines on knee MRI imaging, although the MTUS did in fact address the bulk of the request at hand. The applicant's attorney subsequently appealed. A September 10, 2013 orthopedic consultation was notable for comments that the applicant reported multifocal pain syndrome following a trip and fall injury on June 12, 2008. The applicant had apparently had a variety of treatment over the course of the claim, including aquatic therapy, physical therapy, and corticosteroid injection therapy, it was acknowledged. The applicant reportedly had 10/10 pain in some body parts and reportedly had only minimal, on and off hip pain, 0/10, it was stated. Decreased sensorium was noted about the right upper extremity with right upper extremity and right lower extremity strength ranging from 4+ to 5- to

5/5 in various groups. The applicant did have a positive McMurray sign about the left knee. The attending provider sought electrodiagnostic testing of the upper and lower extremities to determine the extent of the applicant's ongoing radicular complaints. MRI imaging of the shoulders, elbows, wrists, hands, knees were also sought on the grounds that the applicant had never had MRIs of any of the body parts in question. A spine surgery consultation was suggested to evaluate the applicant's ongoing multifocal pain complaints. A pain management consultation was also sought. The applicant was placed off of work, on total temporary disability, for four weeks. It was noted that left shoulder plain film imaging was performed in the clinic setting and was notable for mild acromioclavicular degenerative joint disease. X-rays of the right shoulder were likewise notable for mild-to-moderate acromioclavicular joint disease, x-rays of the left elbow were notable for mild degenerative changes, x-rays of the right elbow were notable for mild degenerative changes, x-rays of the right wrist were notable for mild degenerative changes, x-rays of the left wrist were notable for mild degenerative changes, x-rays of the right knee were notable for moderate-to-severe degenerative joint disease, x-rays of the left knee were notable for moderate medial compartment degenerative joint disease, and x-rays of the left knee were notable for mild degenerative changes, per the attending provider. The films do not appear to have been over read by radiology, it is incidentally noted. On October 24, 2013, the applicant did undergo electrodiagnostic testing of the bilateral upper and bilateral lower extremities. Testing was notable for edema without any left-sided median neuropathy at the wrist with any evidence of a cervical radiculopathy or lumbar radiculopathy appreciated elsewhere.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**PAIN MANAGEMENT CONSULTATION:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, CHAPTER 7, PAGE 127.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 1.

**Decision rationale:** As noted on page 1 of the MTUS Chronic Pain Medical Treatment Guidelines, the presence of persistent complaints which prove recalcitrant to conservative management should lead the primary treating provider to reconsider the operating diagnosis and determine whether a specialist evaluation is necessary. In this case, the applicant has multifocal pain complaints, has failed to respond favorably to conservative management, and is off of work of, on total temporary disability. Obtaining the added expertise of a physician specializing in chronic pain, such as a pain management physician, is therefore indicated. Accordingly, the request is medically necessary.

**MRI OF LEFT SHOULDER:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-208.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 214.

**Decision rationale:** While the MTUS-adopted ACOEM Guidelines in Chapter 9, Table 9-6, page 214 do recommend MRI imaging of the shoulder in the preoperative evaluation of partial-thickness or large full-thickness rotator cuff tears, in this case, however, there is no evidence that the applicant is actively considering or contemplating a shoulder surgery. The multiplicity and multifocal nature of the applicant's complaints imply that the applicant is not, in fact, actively considering or contemplating shoulder surgery. The applicant, moreover, exhibited 160 to 170 degrees of shoulder range of motion on the September 10, 2013 office visit in question, arguing against the presence of any rotator cuff tear for which shoulder MRI imaging would be indicated. Therefore, the request is not medically necessary.

**MRI OF LEFT KNEE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 1020.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 335-336.

**Decision rationale:** While the MTUS-adopted ACOEM Guidelines in Chapter 13, Table 13-2, pages 335 and 336 do support MRI imaging to help confirm diagnoses of meniscal tears, ACL tears, posterior cruciate ligament tears, collateral ligament tears, and/or patellar tendinitis, ACOEM goes on to note that MRI testing is indicated only if surgery is being contemplated. In this case, however, there was no mention or suggestion that the applicant was actively considering or contemplating knee surgery. The applicant's multifocal pain complaints, furthermore, would imply that the applicant was not, in fact, a surgical candidate insofar as the left knee was concerned. Therefore, the proposed knee MRI is not medically necessary.

**ORTHOPEDIC SURGERY CONSULT TO EVALUATE NECK, MID AND LOW BACK:**  
Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, CHAPTER 7, PAGE 127.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180 AND 305.

**Decision rationale:** As noted in the MTUS-adopted ACOEM Guidelines in Chapter 12, page 305 and the MTUS-adopted ACOEM Guidelines in Chapter 8, page 180, referral for surgical consultation is indicated for applicants who have persistent, severe, and disabling radicular complaints with clear clinical imaging, and/or electrophysiologic evidence of a lesion amenable to surgical correction. In this case, however, the applicant does not have any clear, discrete, large, singular herniated disk or high-grade neuroforaminal stenosis or spinal stenosis which

might be amenable to surgical correction. Rather, the applicant has a variety of multifocal pain complaints. There is no clear evidence of specific, discrete lesion amenable to surgical correction insofar as the neck, mid back, or the low back are concerned. Therefore, the request for an orthopedic spine surgery consultation to evaluate the applicant's neck, mid, and low back pain complaints is not medically necessary.

**EMG RIGHT UPPER EXTREMITY:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

**Decision rationale:** As noted in the MTUS-adopted ACOEM Guidelines in Chapter 8, page 178, EMG and NCV testing may help identify subtle, focal neurologic dysfunction in applicants with neck or arm complaints or both which last greater than three to four weeks. In this case, the applicant was described on a September 10, 2013 office visit in question as reporting complaints of upper extremity pain, paresthesias, numbness, and tingling, right greater than left. EMG testing to determine the presence or absence of a cervical radiculopathy versus carpal tunnel syndrome was indicated, appropriate, and supported by ACOEM. Therefore, the request was/is medically necessary.

**NCV RIGHT UPPER EXTREMITY:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 261.

**Decision rationale:** As noted in the MTUS-adopted ACOEM Guidelines in Chapter 11, page 261, appropriate electrodiagnostic testing, including NCV testing and EMG testing in some cases, can help to distinguish between carpal tunnel syndrome and other suspected considerations, including a possible cervical radiculopathy. In this case, the attending provider did suggest that the applicant had upper extremity pain and paresthesias and, furthermore, stated that both carpal tunnel syndrome and cervical radiculopathy were on the differential diagnosis. Appropriate electrodiagnostic testing, including the nerve conduction testing in question, was indicated to help distinguish between the same. Therefore, the request was medically necessary.

**EMG LEFT UPPER EXTREMITY:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178, 261.

**Decision rationale:** As noted in the MTUS-adopted ACOEM Guidelines in Chapter 8, page 178, EMG or NCV testing is indicated in applicants with persistent neck or arm complaints or both, which last greater than three to four weeks so as to identify neurologic dysfunction about the same. In this case, the applicant did report bilateral upper extremity pain and paresthesias on the office visit in question, September 10, 2013. EMG testing to help distinguish between a suspected cervical radiculopathy versus a possible carpal tunnel syndrome was indicated, appropriate, and supported by the MTUS-adopted ACOEM Guidelines in Chapter 11, page 261. Therefore, the request was likewise medically necessary.

**NCV LEFT LOWER EXTREMITY:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 61.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence.

**Decision rationale:** The MTUS does not address the topic. However, as noted in the Third Edition ACOEM Guidelines, nerve conduction testing is typically normal in a suspected radiculopathy. While nerve conduction testing can help to rule out other causes of lower limb symptoms such as a generalized peripheral neuropathy or peroneal compression neuropathy which could mimic sciatica, in this case, however, the attending provider did not voice any suspicion of any lower extremity peripheral neuropathy being possibly present here. The applicant did not have a medical history notable for systemic conditions such as diabetes, hypothyroidism, or hypertension which would predispose toward development of a lower extremity peripheral neuropathy. Therefore, nerve conduction testing of the left lower extremity was not medically necessary.

**EMG RIGHT LOWER EXTREMITY:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 61.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

**Decision rationale:** As noted in the MTUS-adopted ACOEM Guidelines in Chapter 12, Table 12-8, page 309, needle EMG testing is "recommended" to clarify diagnosis of nerve root dysfunction. In this case, it was stated that the attending provider did in fact suspect a lumbar radiculopathy here. The applicant did report complaints of low back pain radiating to the legs with associated paresthesias about the same. EMG testing to help clarify the presence or absence

of nerve root dysfunction was indicated, appropriate, and supported by ACOEM. Therefore, the request was medically necessary.

**NCV RIGHT LOWER EXTREMITY:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 61.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**Decision rationale:** The MTUS does not address the topic. As noted in the Third Edition ACOEM Guidelines, Low Back Chapter Electromyography section, and nerve conduction testing is usually normal in radiculopathy. While nerve conduction testing can help to rule out other causes of lower limb symptoms such as generalized peripheral neuropathy or peroneal compression neuropathy which could mimic sciatica, in this case, however, the attending provider did not state that any lower extremity peripheral neuropathy was suspected here. Rather, the attending provider stated that a lumbar radiculopathy was the diagnosis which he was attempting to confirm or corroborate. The applicant did not, moreover, have any medical history significant for a systemic disease process such as diabetes, hypertension, or hypothyroidism which would predispose the applicant toward development of a lower extremity peripheral neuropathy. Therefore, the request was not medically necessary.

**RETRO LEFT SHOULDER X-RAY:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 214.

**Decision rationale:** As noted in the MTUS-adopted ACOEM Guidelines in Chapter 9, Table 9-6, routine radiographs to work up shoulder complaints is "not recommended." In this case, the attending provider did not state why plain films of the shoulder were being sought. No clear diagnosis or differential diagnosis was provided. It was not clearly stated, for instance, that the attending provider suspected a calcific tendonitis, fracture, or other specific diagnoses which could have been uncovered on plain film x-ray imaging. Therefore, the request was not medically necessary.

**RETRO LEFT KNEE X- RAY:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence.

**Decision rationale:** The MTUS does not address all indications for a knee x-ray. As noted in the Third Edition ACOEM Guidelines, x-rays are considered the initial test of choice for evaluating applicants with suspected knee osteoarthritis. X-rays are recommended in the evaluation of chronic knee pain, as was present here. In this case, the x-rays in question did reveal evidence of advanced arthritic changes. These did account for the applicant's ongoing complaints of knee pain. Therefore, the request was medically necessary.

**RETRO LEFT HIP X-RAYS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence.

**Decision rationale:** The MTUS does not address the topic. As noted in the Third Edition ACOEM Guidelines Hip and Groin Chapter, indications for x-ray imaging of the hip include evidence of moderate-to-severe hip pain lasting at least a few weeks. In this case, however, the applicant's hip pain was minimal-to-mild. The applicant had no hip pain on the date of the evaluation, September 10, 2013. X-ray imaging was not indicated, given the applicant's absence of complaints pertaining to that body part on the date in question. Therefore, the request was not medically necessary.

**NCV LEFT UPPER EXTREMITY:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 261.

**Decision rationale:** As noted in the MTUS-adopted ACOEM Guidelines in Chapter 11, page 261, appropriate electrodiagnostic studies may help to distinguish between carpal tunnel syndrome and other suspected diagnoses, such as cervical radiculopathy. In this case, the attending provider did posit that the applicant had a cervical radiculopathy superimposed on possible carpal tunnel syndrome. The applicant did have complaints of upper extremity pain and paresthesias with ongoing complaints of neck pain. Obtaining appropriate electrodiagnostic studies to help distinguish between the two possible diagnostic considerations was indicated and appropriate. Therefore, the request was medically necessary.

**EMG LEFT LOWER EXTREMITY:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 61.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints  
Page(s): 309.

**Decision rationale:** As noted in the MTUS-adopted ACOEM Guidelines in Chapter 12, Table 12-8, page 309, EMG testing is "recommended" to help clarify diagnosis of suspected nerve root dysfunction. In this case, the attending provider did posit that a lumbar radiculopathy was suspected here. The applicant did have complaints of low back pain with associated lower extremity paresthesias. Obtaining EMG testing to help establish the presence of nerve root dysfunction was indicated and appropriate. Therefore, the request was medically necessary.