

<b>Case Number:</b>	CM14-0147251		
<b>Date Assigned:</b>	09/15/2014	<b>Date of Injury:</b>	02/25/2011
<b>Decision Date:</b>	11/03/2014	<b>UR Denial Date:</b>	08/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/10/2014

### **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 Internal Medicine, has a subspecialty in Nephrology 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:

This is a 58 year old female with a 2/25/11 injury date. The injury involved the right shoulder and right knee but the mechanism was not provided. In a 7/1/14 follow-up, the patient complains of left knee and right shoulder pain. The provider notes that 2012 nerve studies were unremarkable, but wishes to obtain new upper extremity electromyogram (EMG) studies to re-evaluate carpal tunnel syndrome. The provider notes that x-rays have shown bone-on-bone arthritis of the left knee as well as the right, as wishes to start Hyalgan injections on the left knee. A left knee fluoroscopy was not mentioned. Objective findings included left knee tenderness, weakness to resisted extension, knee extension to 0 degrees, flexion to 120 degrees, and limited cervical range of motion. Diagnostic impression: left knee pain, bilateral carpal tunnel syndrome. Treatment to date: right rotator cuff repair (11/14/13), medications, right knee viscosupplementation injections, physical therapy. A UR decision on 8/11/14 denied the request for fluoroscopy of the left knee on the basis that there was no documentation of left knee complaints or corresponding objective findings. The request for EMG of the bilateral upper extremities was denied because there was no current documentation of specific complaints or objective neurologic findings of the upper extremities.

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

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

**Fluoroscopy of the left knee:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the

MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines= radiography (x-rays) Knee & Leg ( Acute & Chronic)

**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: Myung J.S., Lee J.W., Lee J.Y.. Usefulness of fluoroscopy-guided intra-articular injection of the knee. Journal of the Korean Radiological Society. 2007;56(6):563. Berkoff DJ, Miller LE, Block JE. Clinical utility of ultrasound guidance for intra-articular knee injections: a review. Clin Interv Aging. 2012;7:89-95.

**Decision rationale:** The guidelines state that topical analgesics are largely experimental and are primarily used for neuropathic pain after a trial of first line medications. The guidelines state that any compounded product that contains at least one drug or drug class which is not recommended renders the entire medication to be not recommended. The above medication is a combination of topical flurbiprofen and cyclobenzaprine. Cyclobenzaprine is a musclerelaxant which is not recommended for topical use. There has not been sufficient clinical data to prove a benefit with topical muscle relaxants. Additionally, the request did not indicate a frequency of administration or strength. Based on the guidelines and criteria as well as the clinical documentation stated above, the request is not medically necessary.

**EMG of the bilateral upper extremities QTY:2.00:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guideline, Integrated Treatment /Disability Duration guidelines Forearm, Wrist & Hand ( Acute & Chronic)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 238, TABLE 10-6.

**Decision rationale:** CA MTUS criteria for EMG/NCV of the upper extremity include documentation of subjective/objective findings consistent with radiculopathy/nerve entrapment that has not responded to conservative treatment. However, there is insufficient documentation to support the request in this case. There were no objective exam findings in relation to carpal tunnel syndrome and no indication of prior conservative treatments directed specifically toward carpal tunnel syndrome. Therefore, the request for EMG of the bilateral upper extremities QTY:2.00 is not medically necessary.