

<b>Case Number:</b>	CM14-0164035		
<b>Date Assigned:</b>	10/08/2014	<b>Date of Injury:</b>	03/01/2004
<b>Decision Date:</b>	11/10/2014	<b>UR Denial Date:</b>	10/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/06/2014

### 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 Orthopedic Surgeon and is licensed to practice in Texas. 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 injured worker is a 56-year-old male who reported an injury on 03/01/2004, due to an unknown mechanism of injury. The injured worker reportedly sustained an injury to multiple body parts. The injured worker's treatment history included physical therapy and multiple surgical interventions. The injured worker was evaluated on 10/01/2014. It was documented that the injured worker had ongoing bilateral wrist pain, left elbow pain, left shoulder pain, left knee pain, neck pain, and mid back pain. It was noted that the injured worker had failed to respond to conservative treatments and required surgical intervention of the left knee. Objective findings included tenderness to palpation of the lumbar musculature and extreme laxity of the left lower extremity. There was documentation of pain in both wrists, CMC joints, and first extensors. The injured worker's diagnoses included a discogenic cervical condition, impingement syndrome, back sprain, cubital tunnel syndrome, carpal tunnel syndrome, internal derangement of the left knee, chronic pain syndrome, and wrist pain. A request was made for left knee surgery, refill of tramadol, and EMG studies for the bilateral upper extremities. A Request for Authorization was submitted on 10/01/2014 to support the request.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left knee surgery:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-344.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345. Decision based on Non-MTUS Citation Guidelines (ODG

**Decision rationale:** The American College of Occupational and Environmental Medicine recommends surgical intervention for knee injuries for patients who have clinical examination findings consistent with a pathology identified on an imaging study that have failed to respond to conservative treatment. The clinical documentation submitted for review does indicate that the injured worker has significant knee instability. However, there was no imaging study to support the need for surgical intervention. Furthermore, the request as it is subsequent does not clearly identify what type of procedure is being requested. In the absence of that information, the appropriateness of the request itself cannot be determined. As such, the request for Left Knee Surgery is not medically necessary and appropriate.

**Tramadol ER 150mg #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines Opioids, On-Going Management, Page(s): page(s) 78.

**Decision rationale:** The requested tramadol ER 150 mg #30 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends that continued use of opioids in the management of chronic pain be supported by documented functional benefit, adverse side effects, evidence of pain relief, and evidence that the injured worker is monitored for aberrant behavior. The clinical documentation submitted for review does not identify any significant functional benefit or pain relief resulting from the use of this medication. Additionally, there was no documentation that the injured worker is monitored for aberrant behavior. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested tramadol ER 150 mg #30 is not medically necessary or appropriate.

**EMG Studies of the bilateral upper extremities:** Upheld

**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): 177-170.

**Decision rationale:** The American College of Occupational and Environmental Medicine recommends electrodiagnostic studies for patients who have nonfocal radicular deficits that require a more precise delineation between neural impingement and peripheral nerve impingement. The clinical documentation submitted for review does not provide any evidence

that the injured worker has any symptoms consistent with neural impingement or peripheral nerve impingement. Therefore, the need for an electrodiagnostic study is not supported in this clinical situation. As such, the requested EMG studies of the bilateral upper extremities is not medically necessary and appropriate.