

<b>Case Number:</b>	CM14-0125531		
<b>Date Assigned:</b>	08/13/2014	<b>Date of Injury:</b>	07/04/2006
<b>Decision Date:</b>	02/10/2015	<b>UR Denial Date:</b>	07/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/07/2014

### 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 Emergency 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 injured worker is a 45 year-old female , who sustained an injury on July 4, 2006. The mechanism of injury is not noted. Diagnostics have included: Cervical MRI dated February 28, 2013 reported as showing C5-6 disc bulge. Treatments have included: 3 lumbar surgeries, medications, physical therapy, SI joint injection. The current diagnoses are: failed lumbar surgery, lumbar radiculitis, cervicgia, cervical radiculitis. The stated purpose of the request for EMG Left Upper Extremity was not noted. The request for EMG Left Upper Extremity was denied on July 29, 2014, citing a lack of documentation of medical necessity. The stated purpose of the request for Chiropractic Treatments times 4 - Cervical spine was not noted. The request for Chiropractic Treatments times 4 - Cervical spine was denied on July 29, 2014, citing a lack of documentation of functional improvement. The stated purpose of the request for Left knee joint medial and lateral collateral ligament injection was not noted. The request for Left knee joint medial and lateral collateral ligament injection was denied on July 29, 2014, citing a lack of documentation of knee pathology. Per the report dated July 15, 2014, the treating physician noted complaints of neck pain with radiation to the left middle finger, and low back pain with radiation to both lower extremities. Exam showed cervical tenderness, positive left Spurling's sign, negative straight leg raising test, lumbar tenderness and decreased lumbar range of motion.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**EMG Left Upper Extremity:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178, 173, Chronic Pain Treatment Guidelines Page(s): 99-100.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268-269, 272-273.

**Decision rationale:** The requested EMG Left Upper Extremity, is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Chapter 11 - Forearm, Wrist, Hand Complaints, Special Studies and Diagnostic and Treatment Considerations, page 268-269, 272-273; note that Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option, and recommend electro diagnostic studies with documented exam findings indicative of unequivocal evidence of nerve compromise, after failed therapy trials, that are in need of clinical clarification. The injured worker has neck pain with radiation to the left middle finger, and low back pain with radiation to both lower extremities. The treating physician has documented cervical tenderness, positive left Spurling's sign, negative straight leg raising test, lumbar tenderness and decreased lumbar range of motion. The treating physician has not documented physical exam findings indicative of nerve compromise such as deficits in dermatomal sensation, reflexes or muscle strength. The criteria noted above not having been met, EMG Left Upper Extremity is not medically necessary.

**Chiropractic Treatments times 4 - Cervical spine:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-59.

**Decision rationale:** The requested Chiropractic Treatments times 4 - Cervical spine, is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Manual Therapy and Manipulation, Pages 58-59, recommend continued chiropractic therapy with documented objective evidence of derived functional benefit. The injured worker has neck pain with radiation to the left middle finger, and low back pain with radiation to both lower extremities. The treating physician has documented cervical tenderness, positive left Spurling's sign, negative straight leg raising test, lumbar tenderness and decreased lumbar range of motion. The treating physician has not documented objective evidence of derived functional benefit from completed chiropractic sessions, such as improvements in activities of daily living, reduced workrestrictions or reduced medical treatment dependence. The criteria noted above not having been met, Chiropractic Treatments times 4 - Cervical spine is not medically necessary.

**Left knee joint medial and lateral collateral ligament injection:** 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 ODG Treatment Integrated Treatment/Disability Duration Guidelines Knee & Leg (Acute & Chronic) Back to ODG - TWC Index.

**Decision rationale:** The requested Left knee joint medial and lateral collateral ligament injection is not medically necessary. CAMTUS do not address, however per ODG -TWC ODG Treatment Integrated Treatment/Disability Duration Guidelines Knee & Leg (Acute & Chronic) Back to ODG - TWC Index (updated 03/31/14), "Criteria for Intraarticular glucocorticosteroid injections: Documented symptomatic severe osteoarthritis of the knee according to American College of Rheumatology (ACR) criteria, which requires knee pain and at least 5 of the following: (1) Bony enlargement; (2) Bony tenderness; (3) Crepitus (noisy, grating sound) on active motion; (4) Erythrocyte sedimentation rate (ESR) less than 40 mm/hr; (5) Less than 30 minutes of morning stiffness; (6) No palpable warmth of synovium; (7) Over 50 years of age; (8) Rheumatoid factor less than 1:40 titer (agglutination method); (9) Synovial fluid signs (clear fluid of normal viscosity and WBC less than 2000/mm<sup>3</sup>); - Not controlled adequately by recommended conservative treatments (exercise, NSAIDs or acetaminophen); - Pain interferes with functional activities (e.g., ambulation, prolonged standing) and not attributed to other forms of joint disease. The injured worker has neck pain with radiation to the left middle finger, and low back pain with radiation to both lower extremities. The treating physician has documented cervical tenderness, positive left Spurling's sign, negative straight leg raising test, lumbar tenderness and decreased lumbar range of motion. The treating physician has not documented the criteria note above. The criteria noted above not having been met, Left knee joint medial and lateral collateral ligament injection is not medically necessary.