

<b>Case Number:</b>	CM15-0132222		
<b>Date Assigned:</b>	07/27/2015	<b>Date of Injury:</b>	03/08/2013
<b>Decision Date:</b>	09/03/2015	<b>UR Denial Date:</b>	06/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/08/2015

### 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: Texas, New York, California  
 Certification(s)/Specialty: Preventive Medicine, Occupational 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 applicant is a represented 34-year-old who has filed a claim for chronic low back and knee pain with derivative complaints of anxiety and depression reportedly associated with an industrial injury of March 8, 2013. In Utilization Review report(s) dated June 11, 2015, the claims administrator failed to approve requests for a Doppler arterial ultrasound of the right knee, an MR arthrogram of the right knee, and electrodiagnostic testing of the bilateral lower extremities. The claims administrator referenced a May 27, 2015 progress note and an associated RFA form in its determination. The applicant's attorney subsequently appealed. On April 15, 2015, the applicant reported multifocal complaints of low back and knee pain with derivative complaints of anxiety, irritability, insomnia, and tearfulness. Psychiatric consultation and pain management consultation were sought. Multiple topical compounds were prescribed. The applicant had had earlier knee and lumbar spine MRIs, it was stated, the results of which were not clearly reported. Lumbar MRI imaging dated January 13, 2015 was notable for a 2- to 3-mm broad-based disk protrusion at L4-L5 generating associated canal stenosis, bilateral neuroforaminal narrowing, and bilateral exiting nerve root compromise. A disk protrusion of 2 mm at L5-S1 was also generating associated bilateral exiting nerve root compromise, it was noted. On July 13, 2015, the applicant was described as getting worse. Both low back and knee pain were reported. The applicant did have derivative psychological complaints. The applicant was asked to discontinue manipulative therapy on the grounds that it was ineffective. The applicant was using tramadol, Neurontin, Flexeril, and unspecified topical compounds. An MR arthrogram of the right knee, psychiatric consultation, and electrodiagnostic testing of the

bilateral lower extremities were sought. The attending provider then stated that the applicant had right leg weakness evident. This was not detailed, characterized, or expounded upon, however. Once again, the applicant was placed off of work. Overall commentary was sparse. On May 27, 2015, the applicant was again placed off of work, on total temporary disability owing to ongoing complaints of low back pain with cramping pain about the hip. Ancillary complaints of right knee pain and right knee tingling were reported. The applicant also had issues with anxiety present. Cyclobenzaprine, multiple topical compounds, tramadol, MR arthrography of the knee, a Doppler arterial ultrasound evaluation and electrodiagnostic testing of bilateral lower extremities were sought. Overall commentary was sparse. The laterality of the applicant's radicular pain complaints was not clearly described but appeared to be confined to the right leg. The attending provider did not state why he suspected arterial pathology and/or why he was performing an arterial ultrasound. The applicant was placed off of work, on total temporary disability. The stated diagnoses included herniated nucleus pulposus, lumbosacral sprain, right knee sprain, anterior cruciate ligament sprain, and anxiety. Earlier knee MRI imaging of March 22, 2015 was read as grossly normal.

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

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

#### **Doppler Ultrasound Arterial Evaluation, Right Knee: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints. Decision based on Non-MTUS Citation <http://www.mdguidelines.com/peripheral-vascular-disease>.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 331. Decision based on Non-MTUS Citation Revised 2014 (Resolution 26) ACR/AIUM/SRU Practice Parameter for the performance of Peripheral Arterial Ultrasound using color and spectral doppler.

**Decision rationale:** No, the request for a Doppler arterial ultrasound evaluation of the right knee is not medically necessary, medically appropriate, or indicated here. While the MTUS Guideline in ACOEM Chapter 13, Table 13-1, page 331 does acknowledge that decreased or absent pedal or popliteal pulses, pale, cold skin, paralysis of the distal lower extremities, painful swelling about the popliteal fossa, history of diabetes, history of peripheral vascular disease, a history of recent surgery, and/or history of recent fracture do call into question possible neurovascular compromise for which the arterial duplex ultrasound testing of the knee in question would have been indicated, here, however, the applicant's vascular status was not formally assessed in the May 27, 2015 office visit on which the Doppler ultrasound was ordered. The applicant's pedal pulses were not assessed or palpated. There was no mention of the applicant's having pallor, history of recent surgery, pale, cold skin, decreased or absent pulses, or other signs or symptoms of arterial disease for which the Doppler ultrasound in question would have been indicated. While the American College of Radiology (ACR) does acknowledge that indications for peripheral arterial ultrasound testing include monitoring of previous surgical sites, monitoring of previously identified disease, and/or detection of stenosis or occlusions of the peripheral artery in symptomatic applicants with suspected arterial occlusive disease, here,

however, the attending provider seemingly suggested that he was ordering the Doppler ultrasound for routine evaluation purposes, without actually suspecting bona fide arterial disease. There was no mention of the applicant's having previous arterial surgery involving the right lower extremity. A clear rationale for the right knee arterial duplex ultrasound evaluation in question was not furnished. Therefore, the request is not medically necessary.

**MR Arthrogram of Right Knee: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, 2015, Knee and Leg (Acute & Chronic), MR Arthrography.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 335-336. Decision based on Non-MTUS Citation ACOEM Occupational Medicine Practice Guidelines, 3rd. ed., Knee Disorders, pg. 485MR Arthrogram.

**Decision rationale:** Similarly, the request for an MR arthrogram of the right knee is likewise not medically necessary, medically appropriate, or indicated here. While the MTUS Guideline in ACOEM Chapter 13, Table 13-2, pages 335-336 does acknowledge that MRI imaging can be employed to confirm a diagnosis of meniscus tear, collateral ligament tear, anterior cruciate ligament tear, posterior cruciate ligament tear, patellar tendonitis, etc., ACOEM qualifies its position by noting that such testing is generally not indicated unless surgery is being actively considered or contemplated. Here, there was no mention of how the proposed knee MRI would influence or alter the treatment plan. The May 27, 2015 progress note did not state that the applicant was actively considering or contemplating any kind of surgical intervention involving the injured knee. While the Third Edition ACOEM Guidelines Knee Chapter do acknowledge knee MR arthrography in applicants with negative or equivocal MRI imaging with ongoing suspicion of clinically significant intra-articular pathology such as meniscal tears, here, however, the May 27, 2015 progress note did not clearly state what was sought. The attending provider did not state what was suspected. The attending provider did not state how the proposed knee MR arthrogram would influence or alter the treatment plan. There was no mention of the applicant's considering surgical intervention involving the injured knee based on the outcome of the study in question. Therefore, the request is not medically necessary.

**EMG/NCV of bilateral lower extremities: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints, Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 14 Ankle and Foot Complaints Page(s): 309; 377.

**Decision rationale:** Finally, the request for electrodiagnostic testing of the bilateral lower extremities is not medically necessary, medically appropriate, or indicated here. As noted in the MTUS Guideline in ACOEM Chapter 12, Table 12-8, page 309, EMG testing is deemed "not recommended" for applicants who carry a diagnosis of clinically obvious radiculopathy. Here,

earlier lumbar MRI imaging did demonstrate significant disk protrusion at the L4-L5 and L5-S1 levels with associated exiting nerve root compromise. The applicant's prior positive MRI findings, thus, did definitively establish the diagnosis of lumbar radiculopathy and effectively obviated the need for the electrodiagnostic testing in question. The MTUS Guideline in ACOEM Chapter 14, Table 14-6, page 377 also notes that electrical studies (AKA nerve conduction studies) are "not recommended" absent some clinical evidence of tarsal tunnel syndrome, entrapment neuropathies, etc. Here, however, there was no mention of the applicant's having a suspected tarsal tunnel syndrome, entrapment neuropathy, generalized peripheral neuropathy, diabetic neuropathy, etc., voiced on the May 27, 2015 progress note at issue. Since both the EMG and NCV components of the request were not indicated, the entire request was not indicated. Therefore, the request is not medically necessary.