MAXIMUS Federal Services

| Case Number: | CM15-0138378 | | |
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| Date Assigned: | 07/28/2015 | Date of Injury: | 07/08/2014 |
| Decision Date: | 08/31/2015 | UR Denial Date: | 07/06/2015 |
| Priority: | Standard | Application Received: | 07/16/2015 |

## 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 53-year-old who has filed a claim for chronic knee and low back pain reportedly associated with an industrial injury of July 8, 2014. In a utilization review report dated July 6, 2015, the claims administrator failed to approve requests for electrodiagnostic testing of the left lower extremity and an ultrasound-guided knee corticosteroid injection. The claims administrator referenced progress notes and RFA forms of June 22, 2015 and June 25, 2015 in its determination. The applicant's attorney subsequently appealed. On said June 22, 2015 progress note, the applicant reported ongoing complaints of left knee pain with left lateral ankle pain. Numbness and weakness about the plantar and dorsal aspects of the foot were reported. The applicant had undergone earlier knee meniscectomy surgery, it was reported. The applicant had comorbid diabetes and hypertension, it was acknowledged. Decreased sensorium about the L5 dermatome was appreciated, along with decreased light touch sensation about the sural and superficial peroneal dermatomes. MRI imaging of the knee apparently demonstrated a meniscal tear status post earlier failed surgical repair surgery. The applicant was given a diagnosis of superficial peroneal neuropathy versus L5 radiculopathy. Electrodiagnostic testing of the left lower extremity was sought to delineate between the same. An ultrasound-guided knee corticosteroid injection was sought to see if it made any difference in the applicant's ankle pain and paresthesias. The attending provider acknowledged that he was not certain what the source of the applicant's knee pain complaints was and also endorsed repeat knee MRI imaging.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Electromyograph (EMG) and nerve conduction velocity (NCV) of the left lower extremity:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, EMG.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 377. Decision based on Non-MTUS Citation ACOEM Occupational Medicine Practice Guidelines, 3rd ed., Chronic Pain, pg. 848.

**Decision rationale:** Yes, the proposed EMG and NCV of the left lower extremity was medically necessary, medically appropriate, and indicated here. While the MTUS Guideline in ACOEM Chapter 14, Table 14-6, page 377 does acknowledge that electrical studies (a.k.a. nerve conductions) are not recommended without clinical evidence of tarsal tunnel syndrome or other entrapment neuropathies, here, however, the attending provider stated that the applicant could very well carry a diagnosis of superficial peroneal neuropathy versus occult lumbar radiculopathy in his June 22, 2015 progress note. The attending provider stated that he was unable to explain the applicant's complaints of left lower extremity paresthesias and/or hyposensorium appreciated on exam. The applicant was diabetic, it was further noted. The Third Edition ACOEM Guidelines Chronic Pain Chapter does recommend nerve conduction studies to evaluate a peripheral systemic neuropathy of uncertain cause, such as that associated with diabetes mellitus, i.e., one of the operating diagnoses present here. The electrodiagnostic testing in question, thus, was indicated to delineate the source of the applicant's persistent left lower extremity paresthesias and to differentiate between various diagnostic considerations, including diabetic neuropathy, superficial peroneal neuropathy, lumbar radiculopathy, etc. Therefore, the request is medically necessary.

**Ultrasound guided left knee steroid injection:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Intra-articular injections of hyaluronate.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 339. Decision based on Non-MTUS Citation ACOEM Occupational Medicine Practice Guidelines, Knee Disorders, 3rd. ed., pg. 704.

**Decision rationale:** Conversely, the request for an ultrasound-guided knee corticosteroid injection was not medically necessary, medically appropriate, or indicated here. As noted in the MTUS Guideline in ACOEM Chapter 13, page 339, invasive techniques such as the knee corticosteroid injection at issue are "not routinely indicated." Here, the attending provider did not clearly state what he hoped to accomplish via the knee corticosteroid injection in question. The attending provider speculated as to whether or not the knee corticosteroid injection could or

could not ameliorate the applicant's lower extremity neuropathic pain complaints. It was not clearly stated why a knee intraarticular corticosteroid injection was being performed as the applicant's primary issue was, in fact, left lower extremity neuropathy. The Third Edition ACOEM Guidelines' Knee Chapter further notes that intraarticular glucocorticosteroid injections, as is at issue here, are generally performed without fluoroscopic or ultrasound guidance. Here, the attending provider's June 22, 2015 progress note failed to furnish a compelling rationale for the ultrasound-guidance component of the request in the face of the unfavorable ACOEM position on the same. The attending provider failed to state why he was performing an intraarticular knee corticosteroid injection to target the applicant's primary complaints of left lower extremity paresthesias in the face of the tepid-to-unfavorable ACOEM position on invasive techniques such as the knee cortisone injection in question. Therefore, the request is not medically necessary.