

<b>Case Number:</b>	CM15-0139965		
<b>Date Assigned:</b>	07/29/2015	<b>Date of Injury:</b>	08/18/2014
<b>Decision Date:</b>	09/23/2015	<b>UR Denial Date:</b>	06/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/20/2015

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 55-year-old male who sustained an industrial injury on 8/18/2014 resulting in pain in his left knee, and right wrist pain with loss of sensation. He is diagnosed with left knee internal derangement, and rule out carpal tunnel syndrome. Treatment has included wrist brace and medication with no improvement. The injured worker continues to report left knee and right wrist pain. The treating physician's plan of care includes TENS unit for the right wrist, electromyography and nerve conduction study for the right wrist, MRI of the left knee, and 8 sessions of acupuncture for both the right wrist and left knee. He is on total temporary disability.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TENS (right wrist):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines criteria for use of TENS Page(s): 116.

**Decision rationale:** The patient presents with right wrist and left knee pain. The request is for TENS (RIGHT WRIST). The request for authorization is dated 06/17/15. Physical examination revealed slight tenderness of the left knee to palpation. There is slight tenderness with palpation of the right wrist. Carpal compression test is positive for the right wrist. Valgus test is positive on the left. Patellar grind test is positive for the left knee. Neurological examination demonstrates hypoesthesia at C6 on the right. Range of motion is reduced with pain. Per progress report date 07/14/15, the patient to remain off-work. According to MTUS Chronic Pain Management Guidelines the criteria for use of TENS in chronic intractable pain (p116) "a one month trial period of the TENS unit should be documented (as an adjunct to other treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function during this trial." Per progress report dated 06/09/15, treater's reason for the request is "for home and workplace use to reduce pain, swelling, and inflammation, and as an adjunctive therapy to facilitate range of motion and active physical therapy." Treater does not specify if this request is for a rental or a purchase. MTUS requires documentation of one month prior to dispensing home units. Guidelines also require documentation of use of TENS, as an adjunct to other treatment modalities, within a functional restoration approach. In this case, there is no record that patient has trialed a TENS unit in the past, and a trial would be indicated. Therefore, the request IS NOT medically necessary.

**NCS/EMG to the right wrist:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007). Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back Chapter.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

**Decision rationale:** The patient presents with right wrist and left knee pain. The request is for NCS/EMG TO THE RIGHT WRIST. The request for authorization is dated 06/17/15. Physical examination revealed slight tenderness of the left knee to palpation. There is slight tenderness with palpation of the right wrist. Carpal compression test is positive for the right wrist. Valgus test is positive on the left. Patellar grind test is positive for the left knee. Neurological examination demonstrates hypoesthesia at C6 on the right. Range of motion is reduced with pain. Per progress report date 07/14/15, the patient to remain off-work. For EMG, ACOEM Guidelines page 303 states "Electromyography, including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks." ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11, page 260-262 states: Appropriate electrodiagnostic studies (EDS) may help differentiate between CTS and other conditions, such as cervical radiculopathy. These may include nerve conduction studies (NCS), or in more difficult cases, electromyography (EMG) may be helpful. NCS and EMG may confirm the diagnosis of CTS but may be normal in early or mild cases of CTS. If the EDS are negative, tests may be repeated later in the course of treatment if symptoms persist. Per progress report dated 06/09/15, treater's reason for the request is "to determine cervical radiculopathy

and/or neuropathy." In this case, the patient continues with RIGHT wrist pain. Given the patient's upper extremities symptoms, physical examination findings and diagnosis, EMG/NCV study would appear reasonable. There is no evidence that the patient has had a prior RIGHT upper extremity EMG/NCV study done. The request appears to meet guidelines indication. Therefore, the request IS medically necessary.

**MRI of the left knee:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee Chapter, MRI (magnetic resonance imaging).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341, 342.

**Decision rationale:** The patient presents with right wrist and left knee pain. The request is for MRI OF THE LEFT KNEE. The request for authorization is dated 06/17/15. Physical examination revealed slight tenderness of the left knee to palpation. There is slight tenderness with palpation of the right wrist. Carpal compression test is positive for the right wrist. Valgus test is positive on the left. Patellar grind test is positive for the left knee. Neurological examination demonstrates hypoesthesia at C6 on the right. Range of motion is reduced with pain. Per progress report date 07/14/15, the patient to remain off-work. ACOEM Guidelines Chapter 13 on the Knee, pages 341 and 342 on MRI of the knee, states that special studies are not needed to evaluate post knee complaints until after a period of conservative care and observation. Mostly, problems improve quickly once any of the chronic issues are ruled out. For patients with significant hemarthrosis and history of acute trauma, radiography is indicated to evaluate their fracture. ODG Guidelines, Knee and Leg Chapter under MRI's (magnetic resonance imaging) states: "Indications for imaging- MRI (magnetic resonance imaging): Acute trauma to the knee, including significant trauma (e.g, motor vehicle accident), or if suspect posterior knee dislocation or ligament or cartilage disruption. Non-traumatic knee pain, child or adolescent: non-patellofemoral symptoms. Initial anteroposterior and lateral radiographs non-diagnostic (demonstrate normal findings or a joint effusion) next study if clinically indicated. If additional study is needed. Non-traumatic knee pain, child or adult. Patellofemoral (anterior) symptoms. Initial anteroposterior, lateral, and axial radiographs non-diagnostic (demonstrate normal findings or a joint effusion). If additional imaging is necessary, and if internal derangement is suspected. Non-traumatic knee pain, adult. Non-trauma, non-tumor, non-localized pain. Initial anteroposterior and lateral radiographs non-diagnostic (demonstrate normal findings or a joint effusion). If additional studies are indicated, and if internal derangement is suspected. Non-traumatic knee pain, adult; non-trauma, non-tumor, non-localized pain. Initial anteroposterior and lateral radiographs demonstrate evidence of internal derangement (e.g., Peligrini Stieda disease, joint compartment widening). Repeat MRIs: Post-surgical if need to assess knee cartilage repair tissue. (Ramappa, 2007) Routine use of MRI for follow-up of asymptomatic patients following knee arthroplasty is not recommended. (Weissman, 2011)" Per progress report dated 06/09/15, treater's reason for the request is "to rule out soft tissue pathology of patient's injuries." Review of provided medical records show no evidence of prior MRI of the LEFT knee. Patient's diagnosis includes LEFT knee internal derangement. Physical

examination revealed slight tenderness of the LEFT knee to palpation. Valgus test is positive on the LEFT. Patellar grind test is positive for the LEFT knee. Range of motion is reduced with pain. In this case, the patient continues with pain to LEFT knee, and treater has documented suspicion of "internal derangement." This request appears reasonable and within guidelines indication. Therefore, the request IS medically necessary.

**Acupuncture 2 x 4 to the right wrist:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** The patient presents with right wrist and left knee pain. The request is for ACUPUNCTURE 2 X 4 TO THE RIGHT WRIST. The request for authorization is dated 06/17/15. Physical examination revealed slight tenderness of the left knee to palpation. There is slight tenderness with palpation of the right wrist. Carpal compression test is positive for the right wrist. Valgus test is positive on the left. Patellar grind test is positive for the left knee. Neurological examination demonstrates hypoesthesia at C6 on the right. Range of motion is reduced with pain. Per progress report date 07/14/15, the patient to remain off-work. 9792.24.1. Acupuncture Medical Treatment Guidelines. MTUS pg. 13 of 127 states: " (i) Time to produce functional improvement: 3 to 6 treatments (ii) Frequency: 1 to 3 times per week (iii) Optimum duration: 1 to 2 months. (D) Acupuncture treatments may be extended if functional improvement is documented as defined in Section 9792.20(e)." Per progress report dated 06/09/15, treater's reason for the request is "to decrease muscle spasticity, decrease pain, increase circulation." In this case, it appears the treater is initiating a trial of acupuncture for the patient's symptoms. Review of provided medical records does not indicate the patient previously receiving any acupuncture treatments. Given patient's condition, a trial of acupuncture would be indicated by MTUS guidelines. However, the request for 8 treatments of acupuncture exceeds what is recommended by MTUS. Therefore, the request IS NOT medically necessary.

**Acupuncture 2 x 4 to the left knee:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** The patient presents with right wrist and left knee pain. The request is for ACUPUNCTURE 2 X 4 TO THE LEFT KNEE. The request for authorization is dated 06/17/15. Physical examination revealed slight tenderness of the left knee to palpation. There is slight tenderness with palpation of the right wrist. Carpal compression test is positive for the right wrist. Valgus test is positive on the left. Patellar grind test is positive for the left knee. Neurological examination demonstrates hypoesthesia at C6 on the right. Range of motion is reduced with pain. Per progress report date 07/14/15, the patient to remain off-work. 9792.24.1. Acupuncture Medical Treatment Guidelines. MTUS pg. 13 of 127 states: "(i) Time to produce

functional improvement: 3 to 6 treatments (ii) Frequency: 1 to 3 times per week (iii) Optimum duration: 1 to 2 months. (D) Acupuncture treatments may be extended if functional improvement is documented as defined in Section 9792.20(e)." Per progress report dated 06/09/15, treater's reason for the request is "to decrease muscle spasticity, decrease pain, increase circulation." In this case, it appears the treater is initiating a trial of acupuncture for the patient's symptoms. Review of provided medical records does not indicate the patient previously receiving any acupuncture treatments. Given patient's condition, a trial of acupuncture would be indicated by MTUS guidelines. However, the request for 8 treatments of acupuncture exceeds what is recommended by MTUS. Therefore, the request IS NOT medically necessary.