

<b>Case Number:</b>	CM15-0085732		
<b>Date Assigned:</b>	05/08/2015	<b>Date of Injury:</b>	10/30/2013
<b>Decision Date:</b>	07/08/2015	<b>UR Denial Date:</b>	05/01/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/05/2015

### 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: Utah, Arkansas  
 Certification(s)/Specialty: Family Practice, Sports 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 injured worker is a 38-year-old female who sustained an industrial injury on 10/30/13 when her left foot slipped causing her to fall onto her right knee with resulting right knee pain, burning hip pain with numbness to the right foot. She was medically evaluated that day and received x- rays of the right knee which were unremarkable and was told to ice the right knee and take over- the-counter pain reliever. The following day she was ordered an MRI of the right knee and complained of low back pain (5/10) and right leg pain (8/10). She had right knee swelling which was drained and this offered her relief. She was advised to limit the use of her right knee. She currently complains of low back pain (3-5/10) with pain to the right leg (2-5/10) and right knee (3-9/10). Medication is Tramadol, Naprosyn. Diagnoses include right knee pain with medial facet fissuring complicated with patellofemoral chondromalacia patella; lumbar sprain/ strain; suspected lumbar intervertebral disc without myelopathy; neuritis right lower extremity; right iliotibial band syndrome. Treatments to date include physical therapy; pool therapy; medication; ice; heat; acupuncture which is helpful. Diagnostics include right knee x-ray (10/30/13) early degenerative narrowing in medial compartment of patellofemoral joint; MRI of the right knee (11/21/13) showed mild edema deep to the iliotibial band. In the progress note dated 4/20/15 the treating provider's plan of care includes requests for lumbar MRI to rule out disc lesion associated with her radicular/ lower extremity symptoms; electromyography/ nerve conduction study of the bilateral lower extremities to quantify the degree and location of her nerve dysfunction in the right lower extremity; manipulation three times per week for two weeks; massage therapy six sessions for the lumbar spine.

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

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

**MRI of the lumbar spine, per 04/20/15 order:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chapter 12, Low Back Pain, Page 305.

**Decision rationale:** MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for MRI of the back. MTUS guidelines state the following: Despite the lack of strong medical evidence supporting it, diskography, including MRI, is fairly common, and when considered, it should be reserved only for patients who meet the following criteria: Back pain of at least three months duration. Failure of conservative treatment. Satisfactory results from detailed psychosocial assessment. (Diskography in subjects with emotional and chronic pain problems has been linked to reports of significant back pain for prolonged periods after injection, and therefore should be avoided.) Is a candidate for surgery. Has been briefed on potential risks and benefits from diskography and surgery. The clinical documents lack documentation that the patient has met these criteria. According to the clinical documentation provided and current MTUS guidelines; MRI, as written above, is not indicated as a medical necessity to the patient at this time.

**EMG of the bilateral lower extremities, per 04/20/15 order:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Neck and Upper Back Complaints; page(s) 177-188.

**Decision rationale:** The current request is for EMG/NVC of the bilateral lower extremities. MTUS guidelines were reviewed in regards to this specific case. Clinical documents were reviewed. According to the clinical documents, there is no exam findings of a neuropathy in his lower extremities. The clinical documents are lacking evidence of red flag symptoms or worsening symptoms. There is no clinical documentation evidence for indication of EMG/NVC testing; The EMG/NVC is not indicated as a medical necessity at this time.

**NCS of the bilateral lower extremities, per 04/20/15 order Qty: 2:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Neck and Upper Back Complaints; page(s) 177-188.

**Decision rationale:** The current request is for EMG/NVC of the bilateral lower extremities. MTUS guidelines were reviewed in regards to this specific case. Clinical documents were reviewed. According to the clinical documents, there is no exam findings of a neuropathy in his lower extremities. There is also lack of indication for this exam to be done twice. The clinical documents are lacking evidence of red flag symptoms or worsening symptoms. There is no clinical documentation evidence for indication of EMG/NVC testing; The EMG/NVC is not indicated as a medical necessity at this time

**Chiropractic treatment, 3 times weekly, lumbar spine; Qty: 6: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines manual therapy & manipulation Page(s): 58-60.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation, page(s) 58-60ODG, Neck/upper back chapter.

**Decision rationale:** MTUS guidelines state the following: Manual Therapy and Manipulation recommendations. Ankle & Foot: Not recommended. Carpal tunnel syndrome: Not recommended. Forearm, Wrist, & Hand: Not recommended. Knee: Not recommended: Low back: Recommended as an option. According to the clinical documentation provided and current MTUS guidelines; Chiropractic manipulative treatment is indicated a medical necessity to the patient at this time.

**Massage therapy, lumbar spine, per 04/20/15 order Qty: 6: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines massage therapy Page(s): 60.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Massage Therapy, Page 60.

**Decision rationale:** MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for Massage Therapy. MTUS guidelines state the following: Massage is recommended as an option. This treatment should be an adjunct to other recommended treatment, (e. g. exercise) and it should be limited to 4-6 visits in most cases. The clinical documents state that the patient has been prescribed chiropractic therapy, but the current request exceeds the recommended amount of visits. According to the clinical documentation provided and current MTUS guidelines; massage therapy, as requested above, is not indicated as a medical necessity to the patient at this time.