

<b>Case Number:</b>	CM15-0112973		
<b>Date Assigned:</b>	06/24/2015	<b>Date of Injury:</b>	11/20/2014
<b>Decision Date:</b>	10/09/2015	<b>UR Denial Date:</b>	06/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/11/2015

### 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: 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 injured worker is a 32 year old male with an industrial injury dated 11-20-2014. Treatment consisted of laboratory studies and periodic follow up visits. In a progress note dated 05-12-2015, the injured worker reported occasional moderate stabbing low back pain rated 6 out of 10 and constant right knee pain rated an 8 out of 10. Objective findings revealed tenderness to palpitation of the lumbar paravertebral muscles and posterior right knee with muscle spasms and a positive McMurray's sign. The injured worker's current diagnoses include rule out lumbar disc protrusion, rule out lumbar radiculitis versus radiculopathy and rule out right knee meniscus tear. The treating physician prescribed services for electromyography (EMG)/nerve conduction studies (NCS) of the lumbar spine, electromyography (EMG)/nerve conduction studies (NCS) of the right knee, psychological evaluation, Magnetic Resonance Imaging (MRI) of the lumbar spine, Magnetic Resonance Imaging (MRI) of the right knee, acupuncture twice a week for six weeks, chiropractic visits, twice a week for six weeks, physiotherapy visits, twice a week for six weeks, x-ray of the lumbar spine and x-ray of the right knee, now under review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**EMG/NCS of the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Procedure Summary.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

**Decision rationale:** The ACOEM Guidelines state that electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. The medical records provided for review do not note any neurological dysfunction. The clinical information submitted for review fails to meet the evidence based guidelines for the requested service. EMG/NCS of the lumbar spine is not medically necessary.

**EMG/NCS of the right knee:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Procedure Summary.

**MAXIMUS guideline:** Decision based on MTUS Knee Complaints 2004, Section(s): Special Studies.

**Decision rationale:** The ACOEM Guidelines state that electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with symptoms lasting more than three or four weeks. The medical records provided for review do not note any neurological dysfunction. The clinical information submitted for review fails to meet the evidence based guidelines for the requested service. EMG/NCS of the right knee is not medically necessary.

**Psychological evaluation:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Psychological evaluations.

**Decision rationale:** Psychological evaluations are generally accepted, well-established diagnostic procedures not only with selected use in pain problems, but also with more widespread use in chronic pain populations. Diagnostic evaluations should distinguish between conditions that are preexisting, aggravated by the current injury or work related. Psychosocial evaluations should determine if further psychosocial interventions are indicated. The interpretations of the evaluation should provide clinicians with a better understanding of the patient in their social environment, thus allowing for more effective rehabilitation. I am reversing the previous utilization review decision. Psychological evaluation is medically necessary.

**MRI of the lumbar spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Procedure Summary.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

**Decision rationale:** The MTUS states 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. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. The medical record fails to document sufficient findings indicative of nerve root compromise, which would warrant an MRI of the lumbar spine. MRI of the lumbar spine is not medically necessary.

**MRI of the right knee: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Knee Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg Procedure Summary.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg (Acute & Chronic), MRI's (magnetic resonance imaging).

**Decision rationale:** The Official Disability Guidelines state that an MRI of the knee is indicated if internal derangement is suspected. The patient's physical exam shows only some swelling and tenderness. No red-flag indications are present in the medical record. Detailed evidence of severe and/or progressive deficits has not been documented. MRI of the right knee is not medically necessary.

**Acupuncture twice a week for six weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment 2007.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment 2007.

**Decision rationale:** The Acupuncture Medical Treatment Guidelines state that the initial authorization for acupuncture is for 3-6 treatments. Authorization for more than 6 treatments would be predicated upon documentation of functional improvement. The request for 12 treatments is greater than the number recommended for a trial to determine efficacy. Acupuncture twice a week for six weeks is not medically necessary.

**Chiropractic visits, twice a week for six weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

**Decision rationale:** The request is for 12 visits of chiropractic. The Chronic Pain Medical Treatment Guidelines allow for an initial 4-6 visits after which time there should be documented functional improvement prior to authorizing more visits. The request for 12 chiropractic visits is more than what is medically necessary to establish whether the treatment is effective. The previous reviewer modified the request to allow for six sessions of chiropractic care. Chiropractic visits, twice a week for six weeks is not medically necessary.

**Physiotherapy visits, twice a week for six weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Procedure Summary, Knee and Leg Procedure Summary and Preface, Physical Therapy/Chiropractic Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

**Decision rationale:** The MTUS allows for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Prior to full authorization, therapeutic physical therapy is authorized for trial of 6 visits over 2 weeks, with evidence of objective functional improvement prior to authorizing more treatments. There is no documentation of objective functional improvement and the request is for greater than the number of visits necessary for a trial to show evidence of objective functional improvement prior to authorizing more treatments. Physiotherapy visits, twice a week for six weeks is not medically necessary.

**X-ray of the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Procedure Summary.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

**Decision rationale:** The MTUS states that radiographs of the lumbar spine are indicated when red flags are present indicating fracture, cancer, or infection. The medical record contains no documentation of red flags indicating that a lumbar x-ray is indicated. At present, based on the records provided, and the evidence-based guideline review, the request is non-certified. X-ray of the lumbar spine is not medically necessary.

**X-ray of the right knee:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Knee Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg Procedure Summary.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg (Acute & Chronic), Radiography (x-rays).

**Decision rationale:** Special studies such as an x-ray are not needed unless a red-flag condition is present. Physical exam failed to reveal any evidence of joint effusion, swelling, ecchymosis, deformity, increased warmth, or abrasion/laceration. The findings documented on the chart note failed to meet the minimum criteria stated in the Official Disability Guidelines for x-ray imaging of the knee. X-ray of the right knee is not medically necessary.