

<b>Case Number:</b>	CM15-0119537		
<b>Date Assigned:</b>	07/06/2015	<b>Date of Injury:</b>	05/11/2012
<b>Decision Date:</b>	12/14/2015	<b>UR Denial Date:</b>	05/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/22/2015

### 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: Emergency 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 43 year old male who sustained an industrial injury on 5/11/12. Diagnoses are bilateral knees chondromalacia patellae, clinically, right knee ID, status post right knee arthroscopy 12/23/14, left lateral epicondylitis, left ulnar neuropathy, left carpal tunnel syndrome, lumbar spine sprain/strain, status post right knee arthroscopy 9/3/13, status post left knee arthroscopy 4/1/14, and cervical spine radiculopathy. In a progress report dated 4/30/15 a treating physician notes he has undergone 2 right knee arthroscopies and still has considerable right knee pain. He has had one left knee surgery and notes improvement. His low back improved with epidural injections but those symptoms have recurred. He reports 50% improvement in his cervical spine after the injection. In a progress report dated 5/14/15, a treating physician notes continued complaints of pain in his neck, upper and lower back, left elbow, left wrist, bilateral knees, and upper and lower legs. He has limited range of motion and pain which is rated as neck: 6-7/10, upper back 4-5/10, lower back 8-9/10, left wrist 6-7/10, right knee 8/10, left knee 3-4/10, and bilateral upper/lower legs 4-5/10. He has developed anxiety, depression, stress, nervousness, and insomnia. Work status is noted as work restrictions but he is currently not working and last worked on 5/11/12. Ambien, Anaprox, Voltaren, Restoril, physical therapy, transdermal compounds, home inferential unit, MRI's of the lumbar spine, cervical spine, right and left knee done in 2012, MRI right knee-8/4/14, 4 lumbar spine epidural injections, 1 cervical spine injection, and electromyography/nerve conduction studies 2012. The requested treatment is x-rays of the bilateral knees, cervical and lumbar spine, MRI of the right knee, cervical and lumbar spine, electromyography/nerve conduction studies of bilateral lower extremities, electromyography of bilateral upper extremities, Diclofenac 75 mg

#60 with 2 refills, Omeprazole #30 with 2 refills, Tizanidine 4 mg #30 with 2 refills, labs: CBC, CRP, CPK, Labs: arthritis panel, Labs: chem 8 panel, and Tramadol 50 mg #90 with 2 refills.

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

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

**X-rays of the bilateral knees, cervical and lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, and Low Back Complaints 2004, and Knee Complaints 2004.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back/X-rays, neck/X-rays, Knee/Leg/Radiography (X-rays).

**Decision rationale:** The request is for X-rays of the knees, cervical and lumbar spine. The official disability guidelines state that the indications for x-rays include acute trauma with suspected fracture or clear neurological deficits seen with regards to the cervical and lumbar areas. The presence of these "red flags" would warrant plain film studies. A review of the documents do not reveal evidence of either cervical or lumbar neurologic deficits or a change in neurologic examination. There are inadequate findings which would suggest the presence of "red flags". There is no documentation of recent trauma or suspicion of malignancy or infection. Further, the patient has already undergone extensive imaging of all these areas in the past including MRI studies. As such, the request is not medically necessary.

**MRI of the right knee, cervical and lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, and Low Back Complaints 2004, and Knee Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg (Acute & Chronic)/MRI's, Low Back - Lumbar & Thoracic (Acute & Chronic)/MRI's.

**Decision rationale:** The request is for an MRI of the Knees, cervical, and lumbar spine. Based on the ACOEM guidelines, the qualifications for a cervical MRI include neck pain with radiculopathy if severe or progressive neurologic deficit, suspected cervical spine trauma, or bone or disc margin destruction. Similarly, suspected lumbar fracture after acute trauma and neurologic deficits would be an indication for low back imaging. A knee MRI is indicated after acute significant trauma with suspected dislocation or ligament or cartilage disruption. Routine use of MRI for follow-up of asymptomatic patients following knee arthroplasty is not recommended. In this case, there is inadequate documentation of a change in the neurologic examination of "red flags" to justify an MRI of the cervical or lumbar spine. There is also inadequate evidence of a change in the examination of the patient's knee post-surgically. The

records do not indicate a planned repeat surgical procedure or change in management based on the results of the study. As such the requested MRIs are not medically necessary.

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

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Lumbar & Thoracic (Acute & Chronic)/Nerve conduction studies (NCS), Lumbar/EMGs.

**Decision rationale:** The request is for an EMG/NCV of the lower extremities. The guidelines listed do not support testing in this case. The patient has previously undergone electrodiagnostic studies and imaging studies which revealed lumbosacral radiculopathy in the L4, L5, S1 levels and received an epidural steroid injection. There is clear evidence of radiculopathy and the utility of further testing is not delineated. There is no discussion of how further study will change the course of management as there is no discussion of planned surgery. As such, the request is not medically necessary.

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

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and upper back/EMGs, Neck and upper back/Nerve conduction studies.

**Decision rationale:** The request is for an EMG/NCV of the upper extremities. The guidelines listed do not support testing in this case. This is secondary to previous testing performed revealing C5, C6 radiculopathy which was treated with an epidural steroid injection. There is no change in the neurologic examination noted in the records. As such, the request is not medically necessary.

**Diclofenac 75mg #60 x 2 refills:** Overturned

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic)/NSAIDs.

**Decision rationale:** The request is for the use of the medication diclofenac. The guidelines listed do support the use of an NSAID for the patient's condition. At issue is the quantity requested at one time. The use of this medication requires continued monitoring for

effectiveness and side-effects seen. A one month supply would be indicated, and with re-evaluation, further refills would be appropriate based on the response seen. Therefore, the request for Diclofenac 75mg #60 with 2 refills is medically necessary.

**Omeprazole #30 x 2 refills:** 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): NSAIDs, GI symptoms & cardiovascular risk.

**Decision rationale:** The request is for the use of the medication omeprazole. The guidelines listed do support the use of this drug in cases of gastrointestinal disease secondary to NSAID use. In this case there is documentation of GERD and the use of a proton pump inhibitor would be indicated as such. At issue is the duration of requested initial treatment. As previously indicated, a one-month supply would be justified for both the NSAID and proton-pump inhibitor with re-evaluation for continued use if effective. Therefore, the request for Omeprazole #30 with 2 refills is medically necessary.

**Tizanidine 4mg #30 x 2 refills:** 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): Muscle relaxants (for pain).

**Decision rationale:** The request is for the use of a medication classified as a muscle relaxant. The MTUS guidelines state that this is indicated for short-term use as a second-line option of acute exacerbations of low back pain. In this case, it appears that the patient's pain is chronic in nature. There is inadequate documentation of an acute exacerbation seen to justify use. As such, the request is not medically necessary.

**Labs: CBC, CRP, CPK:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** The request is for blood testing. The ACOEM guidelines state that certain diagnostic tests are appropriate for low back complaints depending on physical exam findings. There is no indication listed for hematologic testing to aid in management of patients with radiculopathy. There are screening measures advised for patients who are on certain medications

including NSAIDS but there is inadequate documentation of the purpose of the inflammatory markers requested. As such, the request is not medically necessary.

**Labs: Arthritis panel:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation  
<http://www.webmd.com/rheumatoid-arthritis/guide/blood-tests>.

**Decision rationale:** The request is for an arthritis panel. The MTUS and ODG guidelines are silent regarding this topic. An arthritis panel includes multiple tests to help determine if the patient has a rheumatologic condition. In this case, this testing is not indicated. This is secondary to inadequate documentation of physical exam findings of a rheumatologic condition. As such, the request is not certified.

**Labs: Chem 8 panel:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** The request is for a chemistry panel. The ACOEM guidelines state that certain diagnostic testing is indicated for low back complains depending on the physical exam. In this case, the test is not indicated. This is secondary to inadequate documentation of the purpose of testing, such as screening measures for renal function. As such, the request is not medically necessary.

**Tramadol 50mg #90 x 2 refills:** 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): Opioids for chronic pain.

**Decision rationale:** The request is for the use of the medication tramadol. This is a pain drug in the category of a centrally acting analgesic. For chronic back pain, it appears to be efficacious for short term pain relief, but long term (>16 weeks) results are limited. It also did not appear to improve function. In this case, the use of this medication is not indicated. This is secondary to the duration of use without improvement in function seen. As such, the request is not medically necessary.