MAXIMUS Federal Services

| Case Number: | CM15-0064528 | | |
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| Date Assigned: | 04/10/2015 | Date of Injury: | 12/27/2005 |
| Decision Date: | 06/08/2015 | UR Denial Date: | 03/13/2015 |
| Priority: | Standard | Application Received: | 04/06/2015 |

## 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, Public Health & General Preventive 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 55 year old female, who sustained an industrial injury on 12/27/2005 as a result of a fall. Treatment to date has included x-rays, physical therapy, MRI studies of the cervical and lumbar spine, lumbar fusion, left shoulder surgery, left knee surgery and medication. On provider visit dated 02/19/2015 the injured worker had reported neck, lower back, left shoulder, right ankle/foot and bilateral knees. On examination of the cervical spine revealed decreased range of motion, tenderness to palpation of suboccipital region and cervical paravertebral muscles, cervical compression test was positive, shoulder compression test was positive bilaterally. Lumbar spine was noted to have a decreased range of motion, palpation of lumbar paraspinals and gluteal muscles revealed tenderness bilaterally and hypertonicity on the right. Palpation of the quadratus lumborum revealed tenderness and hypertonicity bilaterally. Straight leg raise test and Kemp's was positive bilaterally. Range of motion was also noted to be decreased at bilateral shoulders and tenderness was noted. Left knee revealed decreased range of motion. Palpation of the medial joint line and popliteal fossa revealed tenderness. The diagnoses have included chronic cervical strain- rule out disc herniation, lumbar disc herniation, status post lumbar fusion, persistent low back pain with radiculopathy of both lower extremities, left shoulder rotator cuff syndrome, status post left shoulder arthroscopic rotator cuff repair and left knee meniscal tear-status post arthroscopy. The provider requested MR arthrogram of the left knee, MRI of the cervical spine, MRI with contrast of the lumbar spine, EMG (electromyogram)

/NCV (nerve conduction velocity) of the bilateral lower extremities, Norco 10/325 mg #90 and Ultram 50 mg #90 to update diagnostic studies to further evaluate her present condition.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**MR Arthrogram of the left knee:** 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), Knee Chapter.

**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 Chapter, MR arthrography.

**Decision rationale:** The Official Disability Guidelines indicate an MR arthrogram is recommended as a postoperative option to help diagnose a suspected residual or recurrent tear, for meniscal repair, or for meniscal resection of more than 25%. The clinical documentation submitted for review failed to provide a rationale for the requested MR arthrogram of the left knee. Given the above, the request for MR arthrogram of the left knee is not medically necessary.

**MRI of the cervical spine:** 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), Indications for Imaging Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back Chapter, MRIs (magnetic resonance imaging).

**Decision rationale:** The Official Disability Guidelines indicate a repeat MRI is recommended when there is documentation of a significant change in symptoms or findings suggestive of significant pathology. The clinical documentation submitted for review indicated the injured worker had previously undergone an MRI. There was a lack of documentation indicating an injured worker had a significant change in symptoms or findings of a significant pathology. The documentation indicated the request was to update the studies. Given the above, the request for MRI of the cervical spine is not medically necessary.

**MRI with contrast of the lumbar spine:** 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), Lumbar Spine Chapter.

**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 Chapter, MRIs (magnetic resonance imaging).

**Decision rationale:** The Official Disability Guidelines indicate a repeat MRI is recommended when there is documentation of a significant change in symptoms or findings suggestive of significant pathology. The clinical documentation submitted for review indicated the injured worker had previously undergone an MRI. There was a lack of documentation indicating an injured worker had a significant change in symptoms or findings of a significant pathology. The documentation indicated the request was to update the studies. Given the above, the request for MRI of the lumbar spine is not medically necessary.

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

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Nerve conduction studies (NCS).

**Decision rationale:** The American College of Occupational and Environmental Medicine states 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. They do not address NCS of the lower extremities. As such, secondary guidelines were sought. The Official Disability Guidelines do not recommend NCS as there is minimal justification for performing nerve conduction studies when an injured worker is presumed to have symptoms on the basis of radiculopathy. There is no documentation of peripheral neuropathy condition that exists in the bilateral lower extremities. There is no documentation specifically indicating the necessity for both an EMG and NCS. There was a lack of documentation indicating a necessity for bilateral lower extremities electrodiagnostic studies. The sensation was normal on the right and decreased on the left at L5 and S1. Deep tendon reflexes were 2+ in the L4 and S1 nerve roots bilaterally. This request would be supported for a left EMG. However, the remainder of the request would not be supported and as such, it must be denied in its entirety. Given the above, the request for EMG/NCV of the bilateral lower extremities is not medically necessary.

**Norco 10/325 mg, ninety count:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 82 - 86.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management Page(s): 60, 78.

**Decision rationale:** The California MTUS Guidelines recommend opiates for chronic pain. There should be documentation of an objective improvement in function, an objective decrease in pain, and evidence that the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review failed to provide documentation of objective functional improvement and objective decrease in pain and documentation the injured worker was being monitored for aberrant drug behavior and side effects. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Norco 10/325 mg 90 count is not medically necessary.

**Ultram 50 mg, ninety count:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management Page(s): 60, 78.

**Decision rationale:** The California MTUS Guidelines recommend opiates for chronic pain. There should be documentation of an objective improvement in function, an objective decrease in pain, and evidence that the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review failed to provide documentation of objective functional improvement and objective decrease in pain and documentation the injured worker was being monitored for aberrant drug behavior and side effects. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Ultram 50 mg 90 count is not medically necessary.