

<b>Case Number:</b>	CM15-0090964		
<b>Date Assigned:</b>	05/18/2015	<b>Date of Injury:</b>	10/05/2009
<b>Decision Date:</b>	09/23/2015	<b>UR Denial Date:</b>	04/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/11/2015

### 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 50 year old male who sustained an industrial injury on 10/5/09. The injured worker was diagnosed as having discogenic thoracic condition with facet inflammation and left sided radiculopathy, discogenic cervical condition, impingement syndrome of shoulder on the right, internal derangement of the knee bilaterally and carpal syndrome on the right side. Currently, the injured worker was with complaints of discomfort in the neck, back, bilateral shoulders and bilateral knees. Previous treatments included oral pain medication, activity modification, injections, braces, hot/cold wrap, and a transcutaneous electrical nerve stimulation unit. Previous diagnostic studies included radiographic studies and a magnetic resonance imaging. The plan of care was for diagnostics, durable medical equipment and an injection.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Injection to the Iliac Crest left side:** 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) Hip & Pelvis (updated 10/09/14) - Online Version, Sacroiliac joint blocks.

**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), Injection with anesthetics and/or steroids.

**Decision rationale:** According to the Official Disability Guidelines, an injection must be given with the intent of relieving pain, improving function, decreasing medications, and encouraging return to work. Repeat pain and other injections not otherwise specified in a particular section in ODG, should at a very minimum relieve pain to the extent of 50% for a sustained period, and clearly result in documented reduction in pain medications, improved function, and/or return to work. Previous injections did not provide adequate pain relief. Injection to the Iliac Crest left side is not medically necessary.

**MRI without contrast for mid back:** 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 Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), MRIs (magnetic resonance imaging).

**Decision rationale:** The Official Disability Guidelines state that indications for a thoracic MRI include trauma, thoracic pain suspicious for cancer or infection, cauda equina syndrome, or myelopathy. The exam indicates that the patient has complaining of mid back pain without evidence of long track signs, bowel or bladder dysfunction, or progressive neurologic deficit. There is no documentation of any of the above criteria supporting a recommendation of a thoracic MRI. MRI without contrast for mid back is not medically necessary.

**EMG/NCV left lower extremity:** 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 Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), EMGs (electromyography).

**Decision rationale:** According to the Official Disability Guidelines, EMG's are recommended as an option and may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. EMG/NCV left lower extremity is not medically necessary.

**EMG/NCV right lower extremity:** 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 Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Nerve conduction studies (NCS).

**Decision rationale:** According to the Official Disability Guidelines, nerve conduction studies are not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Neurological testing procedures have limited overall diagnostic accuracy in detecting disc herniation with suspected radiculopathy. EMG/NCV right lower extremity is not medically necessary.

**Injection to left knee:** 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 Official Disability Guidelines (ODG) Knee & Leg (Acute & Chronic), Corticosteroid injections.

**Decision rationale:** The Official Disability Guidelines recommend corticosteroid injections into the knee for short-term use only. Intra-articular corticosteroid injection results in clinically and statistically significant reduction in osteoarthritic knee pain 1 week after injection. The beneficial effect could last for 3 to 4 weeks, but is unlikely to continue beyond that. The patient must have documented symptomatic severe osteoarthritis of the knee, and at least 5 of 9 criteria specified by any American College of Rheumatology. The medical record is lacking in documentation of the required criteria. In addition, the imaging studies show that the articular surfaces of both knees are in good condition. Injection to left knee is not medically necessary.

**DME Braces/Wraps:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Blue Cross Clinical UM Guideline, Durable Medical Equipment, Guideline #: CG-DME-10, Last Review Date: 02/13/2014.

**Decision rationale:** According to the Blue Cross Clinical UM Guideline for Durable Medical Equipment, durable medical equipment is considered medically necessary when all of a number of criteria are met including: There is a clinical assessment and associated rationale for the requested DME in the home setting, as evaluated by a physician, licensed physical therapist, occupational therapist, or nurse; and There is documentation substantiating that the DME is clinically appropriate, in terms of type, quantity, frequency, extent, site and duration and is considered effective for the individual's illness, injury or disease; and The documentation supports that the requested DME will restore or facilitate participation in the individual's usual

IADL's and life roles. The information should include the individual's diagnosis and other pertinent functional information including, but not limited to, duration of the individual's condition, clinical course (static, progressively worsening, or improving), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc. The medical record does not contain sufficient documentation or address the above criteria. DME Braces/Wraps is not medically necessary.

**Polar Care 21 day rental:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

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

**Decision rationale:** The Official Disability Guidelines recommend continuous-flow cryotherapy as an option after surgery, but not for non-surgical treatment. Postoperative use generally may be up to 7 days, including home use. However, the effect on more frequently treated acute injuries (eg, muscle strains and contusions) has not been fully evaluated. The available scientific literature is insufficient to document that the use of continuous-flow cooling systems (versus ice packs) is associated with a benefit beyond convenience and patient compliance. Polar Care 21 day rental is not medically necessary.

**Crutches:** 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 Blue Cross Clinical UM Guideline, Durable Medical Equipment, Guideline #: CG-DME-10, Last Review Date: 02/13/2014.

**Decision rationale:** According to the Blue Cross Clinical UM Guideline for Durable Medical Equipment, durable medical equipment is considered medically necessary when all of a number of criteria are met including: There is a clinical assessment and associated rationale for the requested DME in the home setting, as evaluated by a physician, licensed physical therapist, occupational therapist, or nurse; and There is documentation substantiating that the DME is clinically appropriate, in terms of type, quantity, frequency, extent, site and duration and is considered effective for the individual's illness, injury or disease; and The documentation supports that the requested DME will restore or facilitate participation in the individual's usual IADL's and life roles. The information should include the individual's diagnosis and other pertinent functional information including, but not limited to, duration of the individual's condition, clinical course (static, progressively worsening, or improving), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with

related items, etc. The medical record does not contain sufficient documentation or address the above criteria. Crutches are not medically necessary.

**Soft Brace:** 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 Blue Cross Clinical UM Guideline, Durable Medical Equipment, Guideline #: CG-DME-10, Last Review Date: 02/13/2014.

**Decision rationale:** According to the Blue Cross Clinical UM Guideline for Durable Medical Equipment, durable medical equipment is considered medically necessary when all of a number of criteria are met including: There is a clinical assessment and associated rationale for the requested DME in the home setting, as evaluated by a physician, licensed physical therapist, occupational therapist, or nurse; and There is documentation substantiating that the DME is clinically appropriate, in terms of type, quantity, frequency, extent, site and duration and is considered effective for the individual's illness, injury or disease; and The documentation supports that the requested DME will restore or facilitate participation in the individual's usual IADL's and life roles. The information should include the individual's diagnosis and other pertinent functional information including, but not limited to, duration of the individual's condition, clinical course (static, progressively worsening, or improving), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc. The medical record does not contain sufficient documentation or address the above criteria. Soft Brace is not medically necessary.

**Hinged Elbow Brace:** 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 Official Disability Guidelines (ODG) Elbow (Acute & Chronic), Splinting (padding).

**Decision rationale:** The Official Disability Guidelines recommend splinting for cubital tunnel syndrome (ulnar nerve entrapment), including a splint or foam elbow pad worn at night (to limit movement and reduce irritation), and/or an elbow pad (to protect against chronic irritation from hard surfaces). No definitive conclusions can be drawn concerning effectiveness of standard braces or splints for lateral epicondylitis. If used, bracing or splinting is recommended only as short-term initial treatment for lateral epicondylitis in combination with physical therapy. Some positive results have been seen with the development of a new dynamic extensor brace but more trials need to be conducted. The patient's symptoms do not meet the requirements set forth by the ODG. Hinged Elbow Brace is not medically necessary.

**Elbow Pad: 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 Official Disability Guidelines (ODG) Elbow (Acute & Chronic), Splinting (padding).

**Decision rationale:** The Official Disability Guidelines recommend splinting for cubital tunnel syndrome (ulnar nerve entrapment), including a splint or foam elbow pad worn at night (to limit movement and reduce irritation), and/or an elbow pad (to protect against chronic irritation from hard surfaces). No definitive conclusions can be drawn concerning effectiveness of standard braces or splints for lateral epicondylitis. If used, bracing or splinting is recommended only as short-term initial treatment for lateral epicondylitis in combination with physical therapy. Some positive results have been seen with the development of a new dynamic extensor brace but more trials need to be conducted. The patient's symptoms do not meet the requirements set forth by the ODG. Elbow Pad is not medically necessary.