

Case Number:	CM13-0031954		
Date Assigned:	03/19/2014	Date of Injury:	04/05/2013
Decision Date:	04/25/2014	UR Denial Date:	09/05/2013
Priority:	Standard	Application Received:	10/01/2013

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 34-year-old female who was injured on 04/05/2013. She was involved in a work-related accident as a result of which she sustained injuries to her low back and both knees. She was in the process of doing her regular customary work duties, when she slipped and fell on a wet floor, landing on her buttocks. Prior Treatment history includes Deprizine, Dicopanol, Fanatrex, Synapryn, Tabradol, Cyclophene, and Ketoprofen Cream. Comprehensive Treating Physician's report dated 08/27/2013 documented the patient to have complaints of having difficulty sleeping and is often awoken at night due to the pain. The patient states that the symptoms persist but the medications do offer her temporary relief of pain and improve her ability to have restful sleep. She denies any problems with the medications. The pain is also alleviated by activity restrictions. Objective findings revealed the patient ambulates without any assistive devices. She is able to heel-toe walk however, she has pain with heel walking. She is able to squat to approximately 50% of normal due to the pain in the low back. Bilateral knee examination revealed 1+ effusion noted. There is no tenderness at the patella-femoral joint. There is no anterior or posterior cruciate ligament instability. There is no medial or lateral collateral ligament instability. Range of motion of the right knee revealed flexion to 130 degrees and left knee flexion to 135 degrees, with 140 degrees being normal. Neurological examination of bilateral lower extremities revealed sensory response is diminished sensation to pinprick and light touch at the L4, L5 and S1 dermatomes bilaterally. Motor strength is decreased at the bilateral lower extremities secondary to pain. The patient was diagnosed with 1) Lumbar spine herniated nucleus pulposus (HNP); 2) Lumbar radiculopathy; 3) Bilateral knee sprain/strain; 4) Sleep disorder. Comprehensive Treating Physician's report dated 07/29/2013 indicated on physical examination, which is essentially unchanged from exam date 06/28/2013 with the exception of tenderness noted at the spinous processes L5-S1 and at the bilateral posterior

superior iliac spine (PSISs). There are trigger point noted throughout the lumbar spine. Active range of motion (AROM): Flexion to mid tibia, normal 60 degrees; extension 15 degrees, normal 25 degrees; left lateral flexion 15 degrees, normal 25 degrees; right lateral 15 degrees, normal 25 degrees; left rotation 15 degrees, normal 30 degrees; and right rotation 15 degrees, normal 30 degrees. Her straight leg raise is positive at 35 degrees bilaterally; Kemp's test is positive bilaterally and sitting root test is positive bilaterally. Bilateral knee examination revealed 1+ effusion noted. There is also crepitus noted with motion. There is tenderness at the patella-femoral joint. There is no anterior or posterior cruciate ligament instability. There is no medial or lateral collateral ligament instability; Ranges of motion of the bilateral knees demonstrated flexion to 125 degrees bilaterally and extension 0 degrees bilaterally. The Comprehensive Treating Physician's report dated 06/28/2013 is the same as exam dated 05/28/2013. The Comprehensive Treating Physician's report dated 05/28/2013 indicated the patient came in with complaints of radicular low back pain, radiating into the legs and knees associated with muscle spasms. She rates the pain as 7/10. It is constant, moderate to severe. Her pain is aggravated by activities of daily living such as getting dressed and performing personal hygiene. She complains of burning bilateral knee pain and muscle spasms, which she rates, a 7/10. she complains of numbness, tingling, and pain radiating into her feet. Objective findings revealed the patient ambulates without any assistive devices. She is able to heel-toe walk however, she has pain with heel walking. She is able to squat to approximately 50% of normal due to the pain in the low back. Bilateral knee examination revealed 1+ effus

IMR ISSUES, DECISIONS AND RATIONALES

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

LUMBAR SPINE MRI: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 52, 303-304.

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

Decision rationale: As per MTUS guidelines, 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. According to the medical records review, there is subjective evidence of lower back pain radiating to legs despite trial of physical therapy and medications. There is objective evidence of persistent paraspinous tenderness at L5-S1, restricted lumbar ROM, positive SLR, diminished sensation in L4, L5, and S1 dermatomes bilaterally, and decreased strength in bilateral lower extremities.

MRI FOR LEFT KNEE.: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341-343. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg, MRI's

Decision rationale: As per CA MTUS and ODG, MRIs are recommended for suspicion of internal derangement. As per ODG, indications for MRI imaging are as follows: Acute trauma to the knee, including significant trauma or if suspect posterior knee dislocation or ligament or cartilage disruption. For nontraumatic knee pain, initial anteroposterior and lateral radiographs demonstrate evidence of internal derangement. According to the records review, there is subjective complaint of bilateral knee pain, however, on physical exam. There are no objective findings that indicate internal derangement consistent with internal derangement. Additionally, there is no documentation of prior x-ray findings that showed evidence of internal derangement. Thus, the request for MRI of the left knee is non-certified.

MRI FOR RIGHT KNEE.: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation, Chapter 13 Knee Complaints Page(s): 341-343. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg, MRI's.

Decision rationale: As per CA MTUS and ODG, MRIs are recommended for suspicion of internal derangement. As per ODG, indications for MRI imaging are as follows: Acute trauma to the knee, including significant trauma or if suspect posterior knee dislocation or ligament or cartilage disruption. For non-traumatic knee pain, initial anteroposterior and lateral radiographs demonstrate evidence of internal derangement. According to the records review, there is subjective complaint of bilateral knee pain; however, on physical exam, there are no objective findings that indicate internal derangement consistent with internal derangement. Additionally, there is no documentation of prior x-ray findings that showed evidence of internal derangement. Thus, the request for MRI of the right knee is non-certified.