

<b>Case Number:</b>	CM13-0042003		
<b>Date Assigned:</b>	12/20/2013	<b>Date of Injury:</b>	04/16/2009
<b>Decision Date:</b>	02/11/2014	<b>UR Denial Date:</b>	09/24/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/15/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Occupational Medicine and is licensed to practice in MS and CA. He 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 physician reviewer was selected based on his 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 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:

Claimant is 59 year old male with date of injury 4/16/2003. Progress report dated 9/19/2013 states that claimant was injured on 7/13/2013 after stepping at home and felt a large crack in the medial aspect of the right knee. He had an injury on 4/13/2003 to his right knee. The claimant has had four surgeries in the left knee including left total knee arthroplasty and reported history of a severe postoperative infection after the third knee surgery. The claimant also had a fall on 2/19/2011 due to the right knee locking. The claimant has had no surgeries for the right knee. The claimant recently went to the ER with complaints of back pain radiating down to the knee and was diagnosed with sciatica and given steroids. The claimant currently reports mild, dull right knee pain which is worse with walking, with associated grinding, catching, locking, and popping. The claimant also reports pain with uneven surfaces. The claimant has had injection in the right knee in 8/2013 which was not beneficial. On exam, there is tenderness in the medial patella and lateral joint line. There is moderate effusion in the right knee. Range of motion in the right knee is full extension to 115 degrees of flexion. McMurray test is positive medially and laterally in the right knee. Range of motion in the left knee is 0-120 degrees. Sensory perception in the foot to light stroke is normal. X-ray of the right knee reveals minimal arthritis while the left knee shows total knee arthroplasty with no evidence of loosening. MRI of the right knee dated 8/1/2013 reveals interstitial tears within the distal quadriceps tendon and patellar ligamentous insertion. There is chondromalacia patella along the medial patellar facet with subchondral patellar edema. There is edema present within the medial aspect of the distal patellar tendon. There is extensive subcutaneous edema anteriorly and there is either edema or bursitis anterior to the insertion of the patellar tendon. There is large effusion noted as well

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CT of the left knee:** Upheld

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

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

**Decision rationale:** The recent progress notes explain symptoms and findings in relation to the right knee, however there is little documented about the left knee. The claimant has a history of left total knee arthroplasty, and the requesting provider reports that the left knee is worsening, however little is written to clarify how the knee is worsening or what is expected from the CT scan. Per ACOEM Guidelines, "Reliance only on imaging studies to evaluate the source of knee symptoms may carry a significant risk of diagnostic confusion (false-positive test results) because of the possibility of identifying a problem that was present before symptoms began, and therefore has no temporal association with the current symptoms. Even so, remember that while experienced examiners usually can diagnose an ACL tear in the non-acute stage based on history and physical examination, these injuries are commonly missed or over diagnosed by inexperienced examiners, making MRIs valuable in such cases. Also note that MRIs are superior to arthrography for both diagnosis and safety reasons. Table 13-5 provides a general comparison of the abilities of different techniques to identify physiologic insult and define anatomic defects." It is noted that in Table 13-5, the CT scan is a test that is not likely to identify knee pathology. The request for CT scan of the left knee is not supported by these guidelines, and is not clearly explained in the medical documentation of why this imaging study would be medically necessary. Following review of the medical documents provided, it is determined that the request for CT scan of the left knee is not medically necessary.

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

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

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

**Decision rationale:** The progress notes report that the claimant went to the ER with back pain and was diagnosed with sciatica. The claimant was treated with medications, and then returned to the ER 12 days later after treatment with steroids, dilaudid and flexeril. The primary treating provider states that the claimant's pain is likely neuritic and should have EMG/NCV studies. There is no clinical documentation other than the report of going to the ER that substantiates ongoing neuritic pain and failed treatment. Per the ACOEM Guidelines, "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." Neurologic dysfunction

with a month of failed treatment is not substantiated by the clinical documents provided for review. The request for EMG/NCV studies is determined to not be medically necessary.