

<b>Case Number:</b>	CM14-0006448		
<b>Date Assigned:</b>	01/24/2014	<b>Date of Injury:</b>	02/24/2011
<b>Decision Date:</b>	06/12/2014	<b>UR Denial Date:</b>	01/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/16/2014

### 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 Orthopedic Surgery, and is licensed to practice in Mississippi and Texas. 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 record notes a 54-year-old male with a date of injury of February 24, 2011. The record indicates that the claimant is status post left knee arthroscopy performed in October 2012, and a right knee arthroscopy performed in January 2013. An orthopedic evaluation in May 2011 indicates that the claimant had pain in the low back with radiation of pain and paresthesias into the left buttock and leg with weakness. Right knee anteromedial pain with catching and giving way was reported. An MRI of the right knee was suggested and an intra-articular corticosteroid injection into the right knee was provided. Home exercises were recommended. An MRI of the lumbar spine was provided in April 2011 and revealed multiple disc protrusions at L3-4, L4-5, and L5-S1. The most significant level was L4-5. 3.5-4.5 mm broad-based disc protrusions were present at all five lumbar interspaces with the most pronounced degenerative changes noted to be at the L1-2 level. At the L4-5 level, a 4 mm disc protrusion, to the left, resulted in compromise of the left neural foramina as well as mild central stenosis. Electrodiagnostic testing identified at L5 denervation. A February 2013 report indicates that the claimant underwent right knee arthroscopy. Synvisc injections were recommended. A peer review in May 2013 was completed for a total knee replacement surgery and non-certified. In June 2013, the record notes that the claimant was unhappy with the previous physician who would not prescribe enough pain medication. Bilateral knee pain, right greater than left was reported. Synvisc injections were recommended, and subsequently certified. On November 5, 2013, the claimant presents for consultation and the treatment history is reviewed. Treatment has included physical therapy, acupuncture, chiropractic therapy, and pharmacotherapy, all providing temporary relief. The record indicates the claimant was drinking alcohol more often. The majority of the complaints center around the knee pain, noted at 8/10 on the right and 7/10 on the left, with episodes of buckling and giving way on the left. The record indicates the claimant developed insomnia and

frustration related to the injury, and stress. Physical examination revealed a 5 foot tall individual weighing 236 pounds. Ambulation is noted with a single point cane. Lumbar range of motion is painful and limited. Positive Kemps test and straight leg raise bilaterally is noted. Crepitus is present in the bilateral knees with moderate effusion of the right knee. Right knee range of motion is 0-110 and left knee range of motion is 0-120. A positive patellofemoral grind test is present bilaterally with positive varus stressing of the right knee. 4/5 strength with knee extension/flexion is noted bilaterally. Otherwise the lower extremity strength is 5/5. The diagnoses include lumbar disc syndrome, and bilateral knee osteoarthritis. The treatment recommendation is for referral for aquatic therapy, pharmacotherapy, a cortisone injection for the right knee, a right total knee arthroplasty, x-rays of the bilateral knees, and an updated MRI of the lumbar spine and the bilateral knees. Additionally, a urine toxicology screen is recommended.

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

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

**REPEAT LUMBAR SPINE MAGNETIC RESONANCE IMAGING:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287.

**Decision rationale:** The ACOEM supports the use of MRI for lumbar spine symptomatology, when there are unequivocal objective findings that identify specific nerve root compromise and surgical or invasive procedures are being considered. In this clinical setting, an initial MRI has already been provided. The guidelines do not recommend repeat MRI as a routine measure, noting that this should be reserved for significant change in symptomatology and/or findings suggestive of significant pathology. The record provides no documentation of a change in symptomatology from the claimant's baseline to warrant this request for repeat MRI of the lumbar spine. As such, the request is not medically necessary.