

<b>Case Number:</b>	CM14-0159543		
<b>Date Assigned:</b>	10/03/2014	<b>Date of Injury:</b>	06/26/2013
<b>Decision Date:</b>	12/30/2014	<b>UR Denial Date:</b>	09/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/29/2014

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine 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 49 year old male with an injury date of 06/26/13. Based on the progress report dated 08/28/14, the patient complains of low back pain that radiates to the legs, left greater than right. There is numbness and tingling in left knee and left thigh. Physical examination of the lumbar spine reveals tenderness to palpation. There is tenderness in the left knee joint and spasm in the left thigh. Straight leg raise is positive, left greater than right. Patellar compression is positive. As per progress report dated 08/14/14, the patient complains of medial inferior/superior pain rated at 5/10; lateral inferior pain rated at 5/10 along with superior lateral knee numbness. Physical examination of the knee reveals flexion of 90/110 and extension of 0, along with mild to moderate numbness in the lateral superior aspect of the knee. The patient underwent left knee arthroscopy, as per progress report dated 08/28/14. The patient is using medications (names not specified) as needed to manage the pain, as per the same progress report. The patient was prescribed hot/cold packs, electric stimulation, phonophoresis, and isometric strengthening (other parts of the reports are illegible). The patient has been allowed to return to full duty without any restrictions, as per progress report dated 08/28/14. X-ray of Bilateral Knees, as per progress report dated 07/24/14: Medial joint space narrowing, MRI of the Lumbar Spine, 07/14/14:- L5-S1: 3.3mm broad-based left paracentral disc protrusion effaces the thecal sac and combined with facet hypertrophy narrows the neural foraminal and lateral recess encroaching the exiting and transiting nerve roots. -L4-5: 2.3mm broad-based central disc protrusion effaces the thecal sac and combined with facet hypertrophy narrows the neural foraminal and lateral recess encroaching the exiting and transiting nerve roots. - L3-4: 2.3mm broad-based diffuse effaces the thecal sac and narrows the neural foraminal and lateral recess encroaching the exiting nerve roots. - L2-3: 2.3mm broad-based diffuse effaces the thecal sac, - Mild discogenic spondylosis

L2-S1, - Mild facet arthrosis L4-S1, - Mild epidural lipomatosis L2-4, - Schmorls nodes, T11 - L4, Diagnosis, 08/28/14, S/P Left Knee Arthroscopic Surgery, Symptomatic. The treater is requesting for (a) Physiotherapy 2 X 4 For The Lumbar Spine (B) Physiotherapy 2 X 4 For The Left Knee (C) MR Arthrogram For The Left Knee. The utilization review determination being challenged is dated 09/17/14. The rationale is as follows: (a) Physiotherapy 2 X 4 For The Lumbar Spine - "The claimant has had extensive PT/Chiro for this condition." There is no documentation of subjective benefits or objective improvements. (b) Physiotherapy 2 X 4 For The Left KNEE - "The claimant has had extensive PT/Chiro for this condition." There is no documentation of subjective benefits or objective improvements.(c) MR Arthrogram For The Left Knee - "The AP did not provide a detailed knee exam." Treatment reports were provided from 05/07/14 - 08/28/14.

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

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

**Physiotherapy 2x4 for the lumbar spine:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98, 99.

**Decision rationale:** The patient presents with low back pain that radiates to the legs, left greater than right along with numbness and tingling in left knee and left thigh, as per progress report dated 08/28/14. The knee pain is rated at 5/10, as per progress report dated 08/14/14. The request is PHYSIOTHERAPY 2 X 4 FOR THE LUMBAR SPINE. MTUS Guidelines pages 98 to 99 state that for patients with "myalgia and myositis, 9 to 10 sessions over 8 weeks are allowed, and for neuralgia, neuritis, and radiculitis, 8 to 10 visits over 4 weeks are allowed." Available progress reports do not discuss prior physical therapy to the lumbar spine. However, Utilization Review Denial Letter states that "This patient has had extensive PT/chiro for this chronic condition." The UR letter does not reveal the date of the therapy, the number of sessions provided to the patient, and the body part that was addressed during the treatment. The treater does not discuss a rationale either. There is no documentation of a flare-up, exacerbation or decline in function to warrant a course of therapy. The patient is working full-time and it is not known why therapy is being requested. Given the lack of adequate discussion, recommendation is for denial.

**Physiotherapy 2x4 for the left knee:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98-99.

**Decision rationale:** The patient presents with low back pain that radiates to the legs, left greater than right along with numbness and tingling in left knee and left thigh, as per progress report dated 08/28/14. The knee pain is rated at 5/10, as per progress report dated 08/14/14. The request is PHYSIOTHERAPY 2 X 4 FOR THE LEFT KNEE. MTUS Guidelines pages 98 to 99 state that for patients with "myalgia and myositis, 9 to 10 sessions over 8 weeks are allowed, and for neuralgia, neuritis, and radiculitis, 8 to 10 visits over 4 weeks are allowed." Available progress reports do not discuss prior physical therapy to the lumbar spine. In progress report dated 08/14/14, the treater states that therapy is "to increase strength/power and endurance on knee extension, medial and lateral biomechanics." However, the Utilization Review Denial Letter states that "This patient has had extensive PT/chiro for this chronic condition." The UR letter does not reveal the date of the therapy, the number of sessions provided to the patient, and the body part that was addressed during the treatment. Based on the available information, it is difficult to decipher the extent of physiotherapy the patient has received in the past. Since the physician's request for 8 sessions is not excessive, recommendation is for authorization.

**MR Arthrogram for the left knee:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Indications for imaging- MRI

**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' and title 'MR arthrography'

**Decision rationale:** The patient presents with low back pain that radiates to the legs, left greater than right along with numbness and tingling in left knee and left thigh, as per progress report dated 08/28/14. The knee pain is rated at 5/10, as per progress report dated 08/14/14. The request is MR ARTHROGRAM FOR THE LEFT KNEE. ODG guidelines, chapter 'Knee & Leg' and title 'MR arthrography', state that the test 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%. In this study, for all patients who underwent meniscal repair, MR arthrography was required to diagnose a residual or recurrent tear. In patients with meniscal resection of more than 25% who did not have severe degenerative arthrosis, avascular necrosis, chondral injuries, native joint fluid that extends into a meniscus, or a tear in a new area, MR arthrography was useful in the diagnosis of residual or recurrent tear. Patients with less than 25% meniscal resection did not need MR arthrography." In this case, the patient underwent left knee arthroscopy with partial medial meniscectomy, synovectomy of the anterior compartment, and chondroplasty of the medial femoral condyle on 10/17/13, as per progress report dated 05/07/14 but he continued to have left knee pain. The treater indicated a request for a MRI of the left knee in the progress report dated 07/24/14. However, in progress report dated 08/28/14, the treater says that the patient "does not need regular MRI to left knee." Instead, the treater requests for MR Arthrogram to rule out the possibility of residual or recurrent tear. The request is reasonable as per ODG guidelines. Recommendation is for authorization.