

Case Number:	CM14-0178568		
Date Assigned:	10/31/2014	Date of Injury:	09/06/2012
Decision Date:	12/08/2014	UR Denial Date:	10/01/2014
Priority:	Standard	Application Received:	10/28/2014

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 Minnesota. 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 request as stated does not specify the type of injection or the level to be injected or the number of injections. Chronic Pain Guidelines recommend epidural steroid injections for treatment of radicular pain defined as pain in a dermatomal distribution with corroborative evidence of radiculopathy on examination. No more than 2 injections are recommended. A home exercise program should be continued at the same time. The records indicate chronic low back pain with tightness on straight leg raising to 10 degrees bilaterally in the supine position. Lasegue and FABERE were negative. Sensation was 4/5 in the right lower extremity and 5/5 in the left. The exact distribution is not documented. Motor exam was negative. Deep tendon reflexes were normal. The documentation does not include objective findings of a radiculopathy corroborating the radicular pain in a dermatomal distribution. A pain management consultation was certified by UR. However, the request for lumbar spine injections is vague and not supported by rationale. In light of the above, the request as stated is not medically necessary per guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right knee arthroscopy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 344 - 345. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg Procedure

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343,344, 345.

Decision rationale: The request as stated is for right knee arthroscopy. It is vague and does not specify if it is for a diagnostic arthroscopy or arthroscopic surgery. There is a history of prior partial medial meniscectomy. The presence of crepitation in the patellofemoral joint with range of motion, the absence of recurring effusions or locking, and the presence of discomfort on palpation of both the medial and lateral joint lines and the negative McMurray on 7/9/2014 indicate that there is no clear evidence that the complex tear of the posterior horn remnant of the medial meniscus is the pain generator. The guidelines indicate surgical consideration if there is documented failure of an exercise program to increase the range of motion and strength and clear signs of a tear on examination and progressive activity limitation which is not documented. No recent exercise program is documented. Patellofemoral syndrome is not an indication for arthroscopy. If there is no progressive activity limitation patients should be encouraged to retain the cushioning property of the meniscus. The diagnosis is fairly clear and a diagnostic arthroscopy is not necessary. Based upon the above, the request for arthroscopy of the right knee is not medically necessary per guidelines.

Pain Management for lumbar spine injections: 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), Low Back Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

Decision rationale: The request as stated does not specify the type of injection or the level to be injected or the number of injections. Chronic Pain Guidelines recommend epidural steroid injections for treatment of radicular pain defined as pain in a dermatomal distribution with corroborative evidence of radiculopathy on examination. No more than 2 injections are recommended. A home exercise program should be continued at the same time. The records indicate chronic low back pain with tightness on straight leg raising to 10 degrees bilaterally in the supine position. Lasegue and FABERE were negative. Sensation was 4/5 in the right lower extremity and 5/5 in the left. The exact distribution is not documented. Motor exam was negative. Deep tendon reflexes were normal. The documentation does not include objective findings of a radiculopathy corroborating the radicular pain in a dermatomal distribution. A pain management consultation was certified by UR. However, the request for lumbar spine injections is vague and not supported by rationale. In light of the above, the request as stated is not medically necessary per guidelines.