

Case Number:	CM14-0100380		
Date Assigned:	07/30/2014	Date of Injury:	06/04/2009
Decision Date:	04/08/2015	UR Denial Date:	06/17/2014
Priority:	Standard	Application Received:	06/30/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Pennsylvania, Ohio, California
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 injured worker (IW) is a 46 year old female who sustained an industrial injury on 06/04/2009. She has reported pain in the lower back with radiation to the left lower extremity and bilateral knee pain. It was noted that the IW had a history of bilateral knee injury dating back five years to June of 2009, and had a permanent and stable designation as of 08/29/2010. She was seen for evaluation of knee pain. Diagnoses include bilateral knee pain, lumbar spine degenerative disc disease. Treatment s to date includes physical/physiotherapy, medications and acupuncture. In a progress note dated 06/05/2014 the treating provider reports left-sided paraspinous tenderness, sacroiliac tenderness, and complaints of radicular symptoms into the left lower extremity. There was anterior joint line tenderness in the knees and no intra-articular effusion of the bilateral knees. On 06/17/2014 Utilization Review non-certified a request for MRI of the bilateral knees without contrast noting there was no documented indications for the requested service. The ACOEM Guidelines, Chapter 13 Knee Complaints were cited. On 06/17/2014, Utilization Review non-certified a request for a MRI of the lumbar spine without contrast noting no red flags. The ACOEM Guidelines Chapter 12 Low Back Complaints were cited. On 06/17/2014 Utilization Review non-certified a request for Physical therapy to the lumbar spine, 2 times per week for 6 weeks, noting "the clinical information provided does not establish the medical necessity of this request." The MTUS Chronic Pain Physical Medicine was cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the bilateral knees without contrast: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee/Leg Chapter Indications for imaging MRI.

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

Decision rationale: MTUS/ACOEM does not recommend relying only on imaging studies to evaluate the source of knee complaints. Implicit in this guideline is the need to consider an MRI knee in the context of a particular differential diagnosis. The rationale and differential diagnosis supporting an MRI knee is not apparent at this time; it is not clear how this would impact the patient's treatment plan. This request is not medically necessary.

MRI of the lumbar spine without contrast: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter Indications for MRI.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

Decision rationale: MTUS/ACOEM recommends lumbar MRI imaging only if there are specific red flags on history and musculoskeletal/neurological examination. The records in this case do not document such red flag findings nor a neurological differential diagnosis to support an indication for a lumbar MRI. The records and guidelines do not support this request. The request is not medically necessary.

Physical therapy to the lumbar spine, 2 times per week for 6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

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

Decision rationale: MTUS encourages physical therapy with an emphasis on active forms of treatment and patient education. This guideline recommends transition from supervised therapy to active independent home rehabilitation. Given the timeline of this injury and past treatment, the patient would be anticipated to have previously transitioned to such an independent home rehabilitation program. The records do not provide a rationale at this time for additional supervised rather than independent rehabilitation. This request is not medically necessary.

