

Case Number:	CM14-0199319		
Date Assigned:	12/09/2014	Date of Injury:	09/08/2011
Decision Date:	01/28/2015	UR Denial Date:	11/18/2014
Priority:	Standard	Application Received:	11/26/2014

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 Occupational Medicine, 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 applicant is a represented [REDACTED] employee who has filed a claim for chronic low back and knee pain reportedly associated with an industrial injury of September 8, 2011. Thus far, the applicant has been treated with the following: Analgesic medications; transfer of care to and from various providers in various specialties; earlier knee ACL reconstruction surgery in October 2013; topical compounds; and extensive periods of time off of work. In a December 15, 2014 progress note, the claims administrator failed to approve request for lumbar MRI imaging, a left knee MR arthrogram, and electrodiagnostic testing of the bilateral lower extremities. The claims administrator referenced a November 3, 2014 DFR in its Utilization Review Report and a subsequent progress note of December 8, 2014. The UR report was quite difficult to follow as the claims administrator wrote at the top of the report that it was denying the request for six sessions of chiropractic manipulative therapy for the knee and low back outright while it went on to state at the bottom of its report that it was modifying the request to allow six sessions of manipulative therapy for the low back alone. The applicant's attorney subsequently appealed. In a progress note dated December 3, 2014, the applicant reported ongoing complaints of knee pain, reportedly severe, 7-8/10. Patellofemoral crepitation was appreciated with -5 to 110 degrees of knee range of motion. The applicant exhibited a well-healed surgical scar with some residual tenderness about the surgical site. Six sessions of chiropractic manipulative therapy for the knee and low back were endorsed, along with a prescription for naproxen. The applicant was given a 15- to 20-pound lifting limitation. It did not appear that the applicant was working with said limitation in place. In an October 17, 2013 permanent and stationary report, the applicant's former treating provider stated that the applicant had been treated with bracing, medications, physical therapy, and ACL reconstruction surgery. The applicant was declared permanent and stationary with an 11% whole-person impairment

rating. On November 3, 2014, the applicant transferred care to a new primary treating provider (PTP). The applicant continued to have left knee and low back pain. The applicant was not working. The applicant reported clicking, locking, buckling, and giving way about the left knee, exacerbated by walking, bending, kneeling, and negotiating stairs, 6/10. Some radiation of low back pain into the bilateral lower extremities was evident. X-rays of the knee taken in the clinic demonstrated degenerative joint disease with osteoarthritis with evidence of the ACL reconstruction. Mild degenerative disk disease at L5-S1 was noted on lumbar spine plain film imaging. Topical compounded medications were endorsed, along with request for eight sessions of physical therapy, lumbar MRI imaging, and MR arthrography of the knee to rule out a recurrent meniscal injury. Electrodiagnostic testing of the bilateral lower extremities was also sought. The applicant was seemingly placed off of work. The requesting provider was an orthopedist, it was stated. It was stated that residual meniscal derangement was suspected.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar spine MRI: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304.

Decision rationale: As noted in the MTUS-adopted ACOEM Guidelines in Chapter 12, page 304, imaging studies should be reserved for cases in which surgery is being considered or red-flag diagnoses are being evaluated. In this case, the applicant's low back pain complaints were described as an ancillary complaint on the Doctor's First Report (DFR) of November 3, 2014, referenced above. That was neither an explicit statement (nor an implicit expectation) that the applicant would act on the results of the proposed lumbar MRI and/or consider surgical intervention involving the same. Therefore, the request is not medically necessary.

MR arthrogram left knee: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee Chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): Table 13-2, 335.

Decision rationale: The primary suspected diagnosis here was that of residual knee meniscal derangement following earlier knee arthroscopy. As noted in the MTUS Guideline in ACOEM Chapter 13, Table 13-2, page 335, MRI imaging can be employed to confirm a diagnosis of meniscal tear but is generally indicated only if surgery is being contemplated. Here, the applicant's primary pain generator was, in fact, the knee. The applicant reported issues with locking, buckling, clicking, and giving way about the injured knee, all of which was, in fact,

highly suggestive of residual meniscal derangement following earlier knee meniscectomy and ACL reconstruction surgery. The applicant had undergone prior knee surgery, suggesting that the applicant would; in fact, consider further surgical intervention based on the results of the study in question. The requesting provider was an orthopedic knee surgeon, again strongly increasing the likelihood that the applicant would act on the results of the study in question and consider surgical intervention based on the outcome of the same. Furthermore, the Third Edition ACOEM Guidelines Knee Chapter notes that MRI arthrogram is recommended for select applicants who require advanced imaging of the menisci following prior procedures. Here, the applicant has, in fact, undergone prior knee surgery. MR arthrography, as suggested by ACOEM, may be superior to conventional MRI imaging in terms of determining new pathology versus scarring or residuals due to prior procedure. Therefore, the request is medically necessary.

EMG/NCV of bilateral lower extremities: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 14 Ankle and Foot Complaints Page(s): Table 12-8, 309; Table 14-6,377. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence; ACOEM V.3, Chronic Pain, Diagnostic / Treatment Considerations, Diagnostic Testing

Decision rationale: While the MTUS Guideline in ACOEM Chapter 12, Table 12-8, page 309 notes that EMG testing is "recommended" to clarify diagnosis of suspected nerve root dysfunction, as may be present here, this recommendation, however, is qualified by commentary made in ACOEM Chapter 12, Table 12-8, page 309 to the effect that EMG testing is "not recommended" for applicants with a clinically obvious radiculopathy. In this case, the current treating provider did not outline what treatment or treatments had transpired through prior treating providers, so it was not clear whether the applicant had or had not had prior imaging or electrodiagnostic testing involving the lumbar spine and/or lower extremities through earlier treating providers. Furthermore, the MTUS Guideline in ACOEM Chapter 14, Table 14-6, page 377 takes the position that electrical studies are "not recommended" for applicants with foot and ankle problems without clinical evidence of tarsal tunnel syndrome or other entrapment neuropathy. In this case, there was no mention of an entrapment neuropathy, compressive neuropathy, diabetic neuropathy, generalized peripheral neuropathy, etc., suspected here. Rather, the attending provider stated that the sole diagnostic consideration here was lumbar radiculopathy. While the Third Edition ACOEM Guidelines Chronic Pain Chapter point out that nerve conduction studies are recommended when there is suspected peripheral neuropathy of uncertain cause, in this case, however, the attending provider did not, in fact, state that peripheral neuropathy was suspected. There was no mention of the applicant's carrying a systemic diagnosis or disease process such as diabetes, hypothyroidism, or alcoholism, etc., which would predispose the applicant toward development of generalized peripheral neuropathy involving the lower extremities. Since both the EMG and NCV components of the request are not indicated, the request is not medically necessary.