

Case Number:	CM14-0215669		
Date Assigned:	01/05/2015	Date of Injury:	04/25/2005
Decision Date:	03/16/2015	UR Denial Date:	12/08/2014
Priority:	Standard	Application Received:	12/23/2014

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: 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 is a 51-year-old female who reported an injury on 04/25/2005. The mechanism of injury was a fall. The injured worker's diagnoses included torn anterior cruciate ligament to the left knee. The injured worker's past treatments included physical therapy, knee brace, medications, and surgical intervention. The injured worker's diagnostic testing included x-rays of the left knee, and were noted to reveal the joint space was well maintained and the patella was intact. Metallic screws were noted in the distal femoral and proximal tibia with tunnels for anterior cruciate ligament noted. An MRI of the left knee was done on 02/27/2012, which was noted to reveal anterior cruciate ligament reconstruction and the ligaments appeared to be intact. There was metallic artifact as a result of the screw present in the distal femur and proximal tibia. There was also patellofemoral arthropathy with some fluid within the left knee joint. The injured worker's surgical history included a left knee anterior cruciate ligament reconstruction on 06/25/2009. On 07/16/2014, the injured worker complained of pain to her low back and left knee. In regards to her low back, she rated her intermittent pain at 8/10 with radiation of pain at times down the back of the left leg to the knee. She reported the pain increased with bending over, lifting, and with prolonged standing or sitting. In regards to her left knee, the patient reported a constant pain of a 9/10, which was mainly localized all around the kneecap region. The left knee was sensitive to touch and the pain increased with walking. There was instability in the left knee and pain upon flexion and extension. Upon physical examination, the injured worker was noted with almost full range of motion of the lumbar spine with low back pain and thoracolumbar pain. She was unable to squat due to bilateral knee pain, the left worse

than the right. There was a patellofemoral click and grind of the right knee with tenderness, but the right knee was dry and had full range of motion. The left knee had full range of motion with AP play but seemed to be dry. There was deformity of the tibial tubercle present with tenderness and sensitivity. There was numbness noted at the lateral aspect of the left knee. The injured worker's medications include ibuprofen. The request was for magnetic resonance angiography of the left knee and 12 sessions of physical therapy (2 times for 6 weeks). The rationale for the request was not clearly provided. The Request for Authorization form was signed and submitted on 07/17/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Magnetic resonance angiography (MRA) left knee: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter MRI's

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, MRI.

Decision rationale: The request for Magnetic resonance angiography (MRA) left knee is not medically necessary. According to the Official Disability Guidelines, a repeat MRI may be indicated postsurgically if needed to assess knee cartilage repair tissue. The patient complained of left knee pain that she rated a 9/10 on a pain scale. She reported the pain was mainly localized all around the kneecap region. The left knee was sensitive to the touch and the pain increased with walking. The patient had pain with flexion and extension of the left knee, and reported instability. Upon physical examination of the left knee, the patient was noted to have full range of motion with AP play, but seemed to be dry. There was deformity of the tibial tubercle present with tenderness and sensitivity. There was numbness at the lateral aspect of the left knee. A previous MRI of the left knee performed on 02/27/2012 revealed patellofemoral arthropathy with some fluid within the left knee joint. A clear rationale for the medical necessity of magnetic resonance angiography of the left knee was not provided. The provider did not provide an adequate description of how a repeat MRA of the left knee will change the treatment plan as previous imaging revealed significant pathology which correlates with the patient's symptoms. Additionally, the documentation did not indicate recent conservative treatment (including physical therapy, home exercise program, and medications). In the absence of documentation with sufficient evidence of tried and failed conservative care, significant change in symptoms since the previous MRA was performed, and a clear rationale and description of how a repeat will change the treatment plan, the request is not supported. Therefore, the request is not medically necessary.

Twelve sessions of Physical Therapy (2x for 6 weeks): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98.

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

Decision rationale: The request for Twelve sessions of Physical Therapy (2x for 6 weeks) is not medically necessary. According to the California MTUS Guidelines, active therapy may be recommended based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self directed home physical medicine. The California MTUS Guidelines may recommend up to 10 visits over 8 weeks. The documentation indicates the patient completed some physical therapy; however, the number of visits and efficacy of the therapy were not included in the documentation. The patient was noted with pain that she rated a 9/10 to the left knee, with full range of motion and deformity of the tibial tubercle present with tenderness and sensitivity. The patient rated her low back pain an 8/10 on a pain scale with radiation of pain at times down to the back of the left leg to the knee. She was noted with almost full range of motion of the lumbar spine with low back pain and thoracolumbar pain. The documentation did not provide sufficient evidence of significant objective functional improvement or significant objective decrease in pain as the result of previously completed physical therapy. In the absence of documentation with sufficient evidence of the number of physical therapy visits completed, documented evidence of significant objective functional improvement, and significant objective decrease in pain, the request is not supported. Additionally, as the request is written, it exceeds the evidence based guidelines. As such, the request is not medically necessary.