

<b>Case Number:</b>	CM15-0132963		
<b>Date Assigned:</b>	07/22/2015	<b>Date of Injury:</b>	08/16/2005
<b>Decision Date:</b>	09/01/2015	<b>UR Denial Date:</b>	06/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/09/2015

### 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: Emergency Medicine

### 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 55 year old female, who sustained an industrial injury on August 16, 2005, incurring low back, and left knee injuries after a slip and fall. She was diagnosed with lumbar disc displacement, lumbar degenerative disc disease, lumbar radiculitis and left knee tendinitis. Treatment included anti-inflammatory drugs, narcotics, physical therapy, acupuncture, left knee arthroscopy in 2006, and a few years later a left knee replacement. In 2013, she underwent extensive back treatment and spinal surgery. Currently, the injured worker complained of persistent left knee pain with ambulation, prolonged and repetitive stair climbing and kneeling. She complained of intermittent low back pain with stiffness. On April 13, 2015, the injured worker underwent a surgical lumbosacral hemi laminectomy followed by steroid injections. The treatment plan that was requested for authorization included transportation to appointments, follow up office visit, x ray of the left knee and physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Transportation to appointments:** 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), Knee & Leg, Transportation to and from appointments.

**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, Transportation (to & from appointments).

**Decision rationale:** The request is for transportation to and from medical appointments. The MTUS and ACOEM guidelines are silent regarding this issue. The ODG guidelines state the following: Recommended for medically necessary transportation to appointments in the same community for patients with disabilities preventing them from self-transport. (CMS, 2009) Note: This reference applies to patients with disabilities preventing them from self-transport who are age 55 or older and need a nursing home level of care. Transportation in other cases should be agreed upon by the payer, provider and patient, as there is limited scientific evidence to direct practice. In this case, transportation is not indicated. The patient does not meet criteria of nursing home level of care. As such, the request is not medically necessary.

**Follow up office visit:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Office visits.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**Decision rationale:** The request is for a medical follow-up visit. The ACOEM guidelines state patients whose complaints are work related should receive follow-up care every 3-5 days by a midlevel provider who can counsel them regarding avoiding static positions, medication use and activity modification. The practitioner can also answer questions, making the sessions interactive. In this case, the patient continues to have discomfort despite the treatment rendered and would qualify for ongoing visits. As such, the request is medically necessary.

**X-ray of the left knee:** 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), X-ray of the knee or leg.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) X-ray knee/leg, Radiography (x-rays).

**Decision rationale:** The request is for x-rays of the knee. The ODG guidelines state the following: Recommended. In a primary care setting, if a fracture is considered, patients should

have radiographs if the Ottawa criteria are met. Among the 5 decision rules for deciding when to use plain films in knee fractures, the Ottawa knee rules (injury due to trauma and age >55 years, tenderness at the head of the fibula or the patella, inability to bear weight for 4 steps, or inability to flex the knee to 90 degrees) have the strongest supporting evidence. A negative result on an Ottawa knee rule test accurately excludes knee fractures after acute knee injury. The pooled negative likelihood ratio is 0.05, the pooled sensitivity is 98.5%, and the pooled specificity is 48.6%. (Bachmann, 2004) (Jackson, 2003) In an emergency room setting, in patients of any age except for infants, the clinical parameters used for not requiring an x-ray following knee trauma are as follows: Patient is able to walk without a limp, and Patient had a twisting injury and there is no effusion. The clinical parameters for ordering knee x-rays in this population following trauma are as follows: Joint effusion within 24 hours of direct blow or fall, Palpable tenderness over fibular head or patella, Inability to walk (four steps) or bear weight immediately or in the emergency room or within a week of the trauma, and Inability to flex knee to 90 degrees. Normal x-ray results can be expected in the absence of immediate swelling, ecchymosis, deformity, increased warmth, or abrasion/laceration. A fracture can be excluded if the single lateral view of the knee is normal, eliminating the need for additional radiographic views. Soft-tissue injuries (meniscal, chondral surface injuries, and ligamentous disruption) are best evaluated by MR. In addition to MR, single photon emission computed tomography (SPECT) has also been reported to be accurate for diagnosing meniscal injuries, while sonography has been shown to be diagnostic for acute anterior cruciate ligament (ACL) injuries in the presence of a hemarthrosis or for follow-up. (ACR, 2001) (Pavlov, 2000) (Goergen, 2000) Studies have suggested that the symptoms of knee osteoarthritis (OA) are rather weakly associated with radiographic findings and vice versa. Based on a review of all studies, the proportion of those with knee pain found to have radiographic osteoarthritis ranged from 15-76%, and in those with radiographic knee OA the proportion with pain ranged from 15% - 81%. The results of knee x rays should not be used in isolation when assessing individual patients with knee pain. (Bedson, 2008) See also ACR Appropriateness Criteria". Indications for imaging- X-rays: Acute trauma to the knee, fall or twisting injury, with one or more of following: focal tenderness, effusion, inability to bear weight First study. Acute trauma to the knee, injury to knee >= 2 days ago, mechanism unknown, Focal patellar tenderness, effusion, able to walk. Acute trauma to the knee, significant trauma (e.g., motor vehicle accident), suspect posterior knee dislocation. Non-traumatic knee pain, child or adolescent; non-patellofemoral symptoms, Mandatory minimal initial exam, Anteroposterior (standing or supine) & Lateral (routine or cross-table). Non-traumatic knee pain, child or adult: patellofemoral (anterior) symptoms, Mandatory minimal initial exam, Anteroposterior (standing or supine), Lateral (routine or cross-table), & Axial (Merchant) view. Non-traumatic knee pain, adult: non-trauma, non-tumor, non-localized pain, Mandatory minimal initial exam, Anteroposterior (standing or supine) & Lateral (routine or cross-table). (ACR, 2001) (Pavlov, 2000) In this case, the patient does not meet the criteria outlined for x-rays as stated above. There is no documentation of an acute event or red flags. There is also no sudden change in the patient's physical examination. As such, the request is not medically necessary.

**Physical therapy 2 times a week for 6 weeks: Upheld**

**Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.**

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Page(s): 56-60 of 127.

**Decision rationale:** The request is for physical therapy to aid in pain relief. The MTUS guidelines states that manipulation is recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. It is indicated for low back pain but not ankle and foot conditions, carpal tunnel syndrome, forearm/wrist/hand pain, or knee pain. The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes. (Fritz, 2007) Active treatments also allow for fading of treatment frequency along with active self-directed home PT, so that less visits would be required in uncomplicated cases. In this case, the patient would benefit most from at home active therapy. As such, the request is not medically necessary.