

Case Number:	CM15-0139191		
Date Assigned:	08/19/2015	Date of Injury:	11/16/2009
Decision Date:	09/18/2015	UR Denial Date:	06/26/2015
Priority:	Standard	Application Received:	07/17/2015

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: Utah, Arkansas

Certification(s)/Specialty: Family Practice, Sports 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 (IW) is a 46 year old female who sustained an industrial injury on 11-16-2009. She reported a slip and fall with injury of the left knee and left hip. The injured worker was diagnosed as having: Pain in pelvic and thigh. Knee pain. Myofascial pain syndrome. At this time she complains of: Lumbar spine strain-sprain, chronic, Lumbosacral radiculopathy, chronic pain syndrome, left knee pain, post-surgical ligament derangement, left hip strain-sprain, rule out tear, and chronic gastritis. Treatment to date has included left knee meniscetomy, physical therapy for the left hip and knee, medications (both oral and topical), and acupuncture for the knee and hip, and chiropractic care. Currently, the injured workers complains of low back, left hip, and left lower extremity pain that increases with weight bearing activities. She also has lumbar pain and decrease in range of motion, lumbar. The treatment plan includes updated diagnostic testing, continuation of physical therapy and chiropractic care, a functional capacity evaluation and cognitive behavioral therapy followed by psychotherapy. A request for authorization was submitted for: 1. Left hip MRI without contrast; 2. Updated MRI of the left knee without contrast; 3. EMG bilateral lower extremity; 4. NCV of the bilateral lower extremity; 5. Continue TENS unit (for indefinite use); 6. Time spent for record review and supplemental report.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left hip MRI without contrast: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation uptodate.com MRI.

Decision rationale: MTUS treatment guidelines are silent with regards to the above request. Other guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for a Hip MRI. The clinical documents state that the patient had a previous MRI of the Hip. There is lack of documentation of changing symptoms that would warrant a repeat MRI. According to the clinical documentation provided and current guidelines; a Hip MRI is not indicated as a medical necessity to the patient at this time.

Updated MRI of the left knee without contrast: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): summary of recommendations, page 347.

Decision rationale: MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for an MRI of the left knee. MTUS guidelines state the following: Recommended MRI study to determine the extent of ACL tear preoperatively. Not recommended for ligament collateral tears. The records state that the patient had a previous MRI of the Knee. There is no further indication for the patient to have another MRI done at this time. According to the clinical documentation provided and current guidelines; a Knee MRI is not indicated as a medical necessity to the patient at this time.

EMG bilateral lower extremity: 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 pgs. 303- 305.

Decision rationale: The current request is for EMG of the bilateral lower extremities. MTUS guidelines were reviewed in regards to this specific case. Clinical documents were reviewed. The records state that the patient had a previous EMG of the lower extremities. There is no further indication for the patient to have another done at this time. According to the

clinical documentation provided and current guidelines; an EMG is not indicated as a medical necessity to the patient at this time.

NCV of the bilateral lower extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303 - 305.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines pgs. 303- 305.

Decision rationale: The current request is for NCV of the bilateral lower extremities. MTUS guidelines were reviewed in regards to this specific case. Clinical documents were reviewed. The records state that the patient had a previous NCV of the lower extremities. There is no further indication for the patient to have another done at this time. According to the clinical documentation provided and current guidelines; a NCV is not indicated as a medical necessity to the patient at this time.

Continue TENS unit (for indefinite use): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Unit, page(s) 113-115.

Decision rationale: MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for TENS unit. MTUS guidelines state the following: Not recommended as a primary treatment modality. While TENS may reflect the long standing accepted standard of care within many medical communities, the results of studies are inconclusive, the published trials do not provide parameters which are most likely to provide optimal pain relief, nor do they answer questions about long-term effectiveness. Several studies have found evidence lacking concerning effectiveness. The patient has used a TENS unit previously and there is lack of documentation for objective and functional improvement. According to the clinical documentation provided and current MTUS guidelines; A TENS unit is not indicated as a medical necessity to the patient at this time.