

<b>Case Number:</b>	CM15-0167832		
<b>Date Assigned:</b>	09/08/2015	<b>Date of Injury:</b>	12/09/2014
<b>Decision Date:</b>	10/13/2015	<b>UR Denial Date:</b>	08/01/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/26/2015

### 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, District of Columbia, Maryland  
 Certification(s)/Specialty: Anesthesiology, Pain Management

### 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 35 year old female who sustained an industrial injury on 12-09-14. Initial complaints and diagnoses are not available. Treatments to date include medications, physical therapy, home exercise program, and acupuncture. Diagnostic studies include x-rays of the lumbar spine, right knee and hip. Current complaints include low back pain radiating to the legs, right hip and right knee pain. Current diagnoses include possible lumbar radiculopathy. In a progress note dated 07-07-15 the treating provider reports the plan of care as a supervised exercise program for the lumbar spine and Voltaren. The requested treatment include MRIs of the lumbar spine and right knee.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Single positional MRI (magnetic resonance imaging) of the lumbar spine:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation ACOEM, Chapter 12 - Low Back Complaints: Special Studies and Diagnostic and Treatment Considerations (2007), page 53; Official Disability Guidelines (ODG), Low Back & Lumbar & Thoracic (Acute & Chronic).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, MRIs (Magnetic resonance imaging).

**Decision rationale:** Per the ODG guidelines with regard to MRI of the lumbar spine: Recommended for indications below. MRI's are test of choice for patients with prior back surgery, but for uncomplicated low back pain, with radiculopathy, not recommended until after at least one month conservative therapy, sooner if severe or progressive neurologic deficit. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, and recurrent disc herniation). (Bigos, 1999) (Mullin, 2000) (ACR, 2000) (AAN, 1994) (Aetna, 2004) (Airaksinen, 2006) (Chou, 2007) Magnetic resonance imaging has also become the mainstay in the evaluation of myelopathy. An important limitation of magnetic resonance imaging in the diagnosis of myelopathy is its high sensitivity. Indications for imaging: Magnetic resonance imaging: Thoracic spine trauma: with neurological deficit. Lumbar spine trauma: trauma, neurological deficit. Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit). Uncomplicated low back pain, suspicion of cancer, infection, other "red flags". Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit. Uncomplicated low back pain, prior lumbar surgery. Uncomplicated low back pain, cauda equina syndrome. Myelopathy (neurological deficit related to the spinal cord), traumatic. Myelopathy, painful. Myelopathy, sudden onset. Myelopathy, stepwise progressive. Myelopathy, slowly progressive. Myelopathy, infectious disease patient. Myelopathy, oncology patient. Repeat MRI: When there is significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation) Per progress report dated 6/15/15, physical examination showed that the patient had positive straight leg raising signs bilaterally. She continued to have low back pain that goes down her right leg. She had started to notice that on the left side. She was refractory to physical therapy and acupuncture. I respectfully disagree with the UR physician's denial based upon a lack of neurological findings, as she exhibits dural tension signs and worsening neuropathic referred pain, possibly radicular. If radicular, this can inform possible procedural management. MRI of the lumbar spine is indicated. The request is medically necessary.

**Single positional MRI (magnetic resonance imaging) of the right knee:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Knee Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg (Acute & Chronic): MRI's (magnetic resonance imaging).

**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's (magnetic resonance imaging).

**Decision rationale:** Per the ODG guidelines regarding MRI of the knee: Recommended as indicated below. Soft-tissue injuries (meniscal, chondral surface injuries, and ligamentous disruption) are best evaluated by MRI. (ACR, 2001) See also ACR Appropriateness Criteria.

Diagnostic performance of MR imaging of the menisci and cruciate ligaments of the knee is different according to lesion type and is influenced by various study design characteristics. Higher magnetic field strength modestly improves diagnostic performance, but a significant effect was demonstrated only for anterior cruciate ligament tears. (Pavlov, 2000) (Oei, 2003) A systematic review of prospective cohort studies comparing MRI and clinical examination to arthroscopy to diagnose meniscus tears concluded that MRI is useful, but should be reserved for situations in which further information is required for a diagnosis, and indications for arthroscopy should be therapeutic, not diagnostic in nature. Indications for imaging: MRI (magnetic resonance imaging): Acute trauma to the knee, including significant trauma (e.g., motor vehicle accident), or if suspect posterior knee dislocation or ligament or cartilage disruption. Non-traumatic knee pain, child or adolescent: non-patellofemoral symptoms. Initial anteroposterior and lateral radiographs non-diagnostic (demonstrate normal findings or a joint effusion) next study if clinically indicated. If additional study is needed. Non-traumatic knee pain, child or adult. Patellofemoral (anterior) symptoms. Initial anteroposterior, lateral, and axial radiographs non-diagnostic (demonstrate normal findings or a joint effusion). If additional imaging is necessary and if internal derangement is suspected. Non-traumatic knee pain, adult. Non-trauma, non-tumor, non-localized pain. Initial anteroposterior and lateral radiographs non-diagnostic (demonstrate normal findings or a joint effusion). If additional studies are indicated, and if internal derangement is suspected. Non-traumatic knee pain, adult – non-trauma, non-tumor, non-localized pain. Initial anteroposterior and lateral radiographs demonstrate evidence of internal derangement (e.g., Peligrini Stieda disease, joint compartment widening). Repeat MRIs: Post-surgical if need to assess knee cartilage repair tissue. (Ramappa, 2007) Routine use of MRI for follow-up of asymptomatic patients following knee arthroplasty is not recommended. (Weissman, 2011) Per the medical records, it is noted that the injured worker continues to have right knee pain, and has a fullness in the posterior aspect of the right knee. However, the physical exam does not indicate any internal derangement of the knee. There is no instability of the right knee. The request is not medically necessary.