

<b>Case Number:</b>	CM15-0182635		
<b>Date Assigned:</b>	09/23/2015	<b>Date of Injury:</b>	09/21/2012
<b>Decision Date:</b>	11/25/2015	<b>UR Denial Date:</b>	08/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/16/2015

### 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: 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 53 year old female, who sustained an industrial-work injury on 9-21-12. She reported initial complaints of lumbar pain. The injured worker was diagnosed as having lumbosacral intervertebral disc degeneration without myelopathy, thoracic or lumbosacral neuritis or radiculitis, and lumbago. Treatment to date has included medication, surgery (discectomy with anterior fusion and right posterior fusion at L4-L5), and diagnostics. Currently, the injured worker complains of back and leg symptoms with 50% improvement since surgery three weeks prior. There is some pain and tingling in the anterior thighs on both sides that does not go past the knee. There is significant incisional back pain. She takes Percocet, Gemfibrozil, Oxycontin, Zoloft, Clonazepam, Ambien, and Gabapentin. Per the primary physician's progress report (PR-2) on 7-30-15, exam notes surgical incision clean and dry to the lumbar region, steri strips to abdominal region, negative straight leg raise bilaterally, normal motor strength, no edema to lower extremities, and used walker for ambulation. Current plan of care includes diagnostic testing to rule out internal derangement. The Request for Authorization requested service to include 1 MRI of the left knee, without contrast. The Utilization Review on 8-17-15 denied the request for 1 MRI of the left knee, without contrast, per Official Disability Guidelines (ODG), Knee & Leg (Acute & Chronic).

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **1 MRI of the left knee, without contrast: 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 (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) Knee and Leg chapter, under Magnetic resonance imaging.

**Decision rationale:** The patient presents on 07/30/15 with improving back and leg pain with residual tingling in the anterior thighs bilaterally. The patient's date of injury is 09/21/12. Patient is status post lumbar discectomy and fusion at L4-5 levels. The request is for 1 MRI OF THE LEFT KNEE, WITHOUT CONTRAST. The RFA was not provided. Physical examination dated 07/30/15 reveals an intact and clean lumbar incision, intact sensation and motor strength in the bilateral lower extremities, and negative straight leg raise testing bilaterally. The patient is currently prescribed Gemfibrozil, Percocet, Soma, Oxycontin, Clonazepam, Ambien, and Gabapentin. Patient is currently classified as temporarily totally disabled. ODG Guidelines, Knee and Leg chapter, under Magnetic resonance imaging states: Indications for imaging -- MRI: Acute trauma to the knee, including significant trauma , or if suspect posterior knee dislocation or ligament or cartilage disruption. Non-traumatic knee pain, child or adolescent: nonpatellofemoral symptoms. Initial anteroposterior and lateral radiographs nondiagnostic next study if clinically indicated if additional study is needed. Nontraumatic knee pain, child or adult. Patellofemoral symptoms, Initial anteroposterior, lateral and axial radiographs nondiagnostic. If additional imaging is necessary and if internal derangement is suspected. Nontraumatic knee pain, adult. Nontrauma, nontumor, nonlocalized pain. Initial anteroposterior and lateral radiographs nondiagnostic. Nontraumatic knee pain, adult - nontrauma, nontumor, nonlocalized pain. Initial anteroposterior and lateral radiographs demonstrate evidence of internal derangement. In regard to the MRI of the left knee, the treater has not provided a reason for the request. There is no evidence that this patient has had any MRI imaging of the knee to date. Per progress note dated 07/30/15, this patient has been experiencing improving lower back pain following recent lumbar fusion surgery, though complaints or physical examination findings specific to the left knee are not provided. Utilization review indicates that this request originated from a progress note dated 08/08/15, with physical examination findings of tenderness to palpation, crepitus, and slightly positive McMurray's sign. However this progress note was not made available for review with the documentation provided. The utilization review non-certified this request on grounds that: "The patient's current complaints are knee pain and his physical examination is consistent with chondromalacia. There's nothing to suggest an internal derangement. The patient's diagnosis is long since been worked out and new diagnostic studies in the absence of a change in his physical examination are not warranted."[sic] It is difficult to establish this patient's current knee pathology without objective complaints or physical examination findings pertinent to the request. The only recent progress note provided for review which specifically addresses knee complaints is dated 05/06/15, with findings of mild crepitus bilaterally - the remainder of the documentation focuses on this patient's lumbar spine complaint. This progress note alone is not sufficient to validate the need MRI imaging at this time. Without evidence of worsening pain or clear documentation suggestive of internal derangement of the left knee, such imaging cannot be substantiated. Therefore, the request IS NOT medically necessary.