

Case Number:	CM15-0190801		
Date Assigned:	10/02/2015	Date of Injury:	06/05/2012
Decision Date:	11/18/2015	UR Denial Date:	08/31/2015
Priority:	Standard	Application Received:	09/28/2015

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, Hawaii

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:

This is a 45 year old male with a date of injury of June 5, 2012. A review of the medical records indicates that the injured worker is undergoing treatment for chronic sprain and strain of the cervicothoracic spine and associated musculoligamentous structures, multilevel cervical disc disease, and chronic right knee pain, consider internal derangement of chondromalacia of the patella. Medical records dated June 12, 2015 indicate that the injured worker complained of right knee pain. A progress note dated July 22, 2015 documented complaints of soreness in the neck and shoulders and in the back. Per the treating physician (July 22, 2015), the employee has not returned to work. The physical exam dated June 12, 2015 revealed crepitus with range of motion of the bilateral knees, decreased strength of the right lower extremity, tenderness over the right medial and lateral patella, and patellofemoral crepitus and grinding bilaterally. The progress note dated July 22, 2015 documented a physical examination that showed decreased range of motion of the cervical spine (flexion of 35 degrees, extension of 42 degrees), tenderness in the cervical paraspinal muscles, decreased range of motion of the lumbar spine, and tenderness at L1 through S1. Treatment has included medications, knee surgeries, home exercise, and magnetic resonance imaging of the right knee (date not documented) that showed chondromalacia of the patella. The original utilization review (August 31, 2015) non-certified a request for MR arthrogram right knee, left cervical interlaminar epidural steroid injection at C6- C7, and motorized colder therapy unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

MR arthrogram right 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) Treatment Integrated Treatment/Disability Duration Guidelines Knee & Leg (Acute & Chronic) (updated 03/31/14).

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, MR Arthrography.

Decision rationale: The patient presents with neck, shoulders and back pain. The current request is for MR Arthrogram right knee. The treating physician's report dated 07/22/2015 (561B) states, "At this point, ██████ remains symptomatic. I would like the benefit of an MR arthrogram of the knee to clarify the internal derangements." The ODG Guidelines under the Knee Chapter on MR Arthrography for the knee states, "Recommended as a postoperative option to help diagnose a suspected residual or recurrent tear, for meniscal repair or for meniscal resection of more than 25%." The treatment report dated 03/12/2015 (520B) states, "He has been having pain to his right knee for the past few years. He states that symptoms have gotten worse. Kneeling and squatting causes him increasing pain. Getting up from sitting position also causes him pain. He states that prolonged standing and walking causes his leg to feel weak. He denies any complaint of knee giving way. He has not had any treatment for his knee recently." Medical records show an MRI of the right knee dated 11/24/2014 (481B) that showed no evidence of meniscal or ligament tear. No fracture or focal trabecular stress reaction is identified. There is a very small anterior joint effusion. In this case, the patient's 2014 MRI of the right knee showed no evidence of meniscal tear. Furthermore, the patient is not post-surgical to warrant an MR arthrogram. The current request is not medically necessary.

Left cervical interlaminar epidural steroid injection C6-C7: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG - TWC Treatment Integrated Treatment/Disability Duration Guidelines Neck and Upper Back (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

Decision rationale: The patient presents with neck, shoulders and back pain. The current request is for Left cervical interlaminar epidural steroid injection C6-C7. The treating physician's report dated 07/22/2015 (561B) states, "I will request authorization for one cervical epidural steroid injection at C6-C7 level using interlaminar approach on the left side. This would be done in order to reduce inflammation and decrease pain and restore function." The physician that originally made the request was ██████ on 04/07/2015 (354B). The MTUS Guidelines page 46 and 47 on epidural steroid injections states that it is recommended as an option for treatment

of radicular pain, as defined by pain in a dermatomal distribution with corroborative findings of radiculopathy in an MRI. MTUS also states, "There is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain." Repeat block should be based on continued objective documented pain and functional improvement including at least 50% pain relief with associated reduction of medication use for 6 to 8 weeks. The MRI of the cervical spine from 12/07/2012 (465B) shows 3-4mm disc protrusion at C6-7 and 3.5-4mm right sided disc protrusion at C5-6. The 04/17/2015 report notes, "He complains of neck pain on the left side of his neck radiating into the left upper extremity. He has had previous cervical epidural steroid injections and all of them have resulted in decreased pain by at least 50% for 8/12 weeks. He is requesting a repeat injection at this point as his last one was last year." The examination in this report notes decreased range of motion with spasms and tenderness in the cervical spine. Spurling's maneuver was positive. In this case, the physician has documented the required criteria based on the MTUS guidelines for repeat blocks. The current request is medically necessary.

Motorized colder therapy unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG - TWC 2012 on the Web (www.odgtreatment.com) Work Loss Data Institute (www.worklossdata.com) (updated 02/14/12).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back Chapter, Continuous Flow Cryotherapy.

Decision rationale: The patient presents with neck, shoulders and back pain. The current request is for Motorized Colder Therapy unit. The treating physician's report dated 07/22/2015 (561B) states, "I would like to order the following for the patient to be utilized post injection: Motorized Cold Therapy unit for purchase only." The physician that originally made the request was [REDACTED] on 04/07/2015 (354B). ODG-TWC, Neck and Upper Back Chapter under Continuous-flow cryotherapy states: "Not recommended in the neck. Recommended as an option after shoulder surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. See the Shoulder Chapter for more information." In this case, the ODG Guidelines do not recommend the use of this modality for the neck. The current request is not medically necessary.