

<b>Case Number:</b>	CM14-0133618		
<b>Date Assigned:</b>	08/22/2014	<b>Date of Injury:</b>	06/25/2010
<b>Decision Date:</b>	09/24/2014	<b>UR Denial Date:</b>	07/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/18/2014

### 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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Interventional Spine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 44-year-old male with an injury date of 06/25/10. The 06/18/14 report by [REDACTED] states that the patient presents with chronic pain of the lumbar spine status post hardware removal from the lumbar spine (May 2014). The patient is visibly uncomfortable, has antalgic gait and ambulates with a walker. He is on temporary total disability and has difficulty with his activities of daily living (ADLs). Examination reveals spasm and tenderness in the paravertebral muscles of the lumbar spine with decreased range of motion. A well healed incision is noted. It is also noted the patient has discomfort with pain on extension and flexion of the left knee. The patient's diagnoses from the 07/17/14 report include: Other mechanical complication of other internal orthopedic device, Lumbosacral radiculopathy, Thoracic of lumbosacral neuritis or radiculitis not otherwise specified, Sprains and strains of the knee and leg not otherwise specified and Status post removal of lumbar hardware (05/09/14). The utilization review being challenged is dated 07/22/14. Treatment reports from 02/08/13 to 07/17/14 were provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CT scan (left knee):** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITIES GUIDELINES - TWC KNEE AND LEG PROCEDURE SUMMARY.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) <Knee and Leg (Acute and Chronic) , Computed tomography (CT) Recommended as an option for pain after TKA with negative radiograph for loosening. One study recommends using computed tomography (CT) examination in patients with painful knee prostheses and equivocal radiographs, particularly for: (1) Loosening: to show the extent and width of lucent zones that may be less apparent on radiographs; (2) Osteolysis: CT is superior to radiographs for this diagnosis; recommend CT be obtained in patients with painful knee prostheses with normal or equivocal radiographs and increased uptake on all three phases of a bone scan to look for osteolysis; (3) Assessing rotational alignment of the femoral component; (4) Detecting subtle or occult periprosthetic fractures. (Weissman, 2006) Three-dimensional CT is not recommended for routine preoperative templating in TKA. (Davis, 2010) (Kobayashi, 2012) (Nowakowski, 2012) See Three-dimensional CT (3D).

**Decision rationale:** The patient presents with chronic pain of the lumbar spine and left knee pain. The provider requests for a CT scan of the left knee in order to provide additional recommendations for the treatment of this body part. The 07/17/14 report states the patient is exhibiting meniscal symptomatology, and it was not possible to provide an MRI due to retained metal. The 05/21/14 report notes the patient's left knee pain with catching, locking and instability. There was no mention of knee pain in the reports provided from 02/08/13 to 04/02/14. The 06/19/13 report references a 01/13/13 Qualified Medical Examiner report recommending a CT scan of the lower extremities; however, this report was not provided. A review of the reports shows no indication of any prior CT scan on the left knee. ODG guidelines under the Procedure Summary--Knee state that computed tomography (CT) is recommended as an option for pain after Total Knee Arthroscopy with negative radiograph for loosening. ACOEM guidelines have the following regarding special studies: (pages 341,342) Special studies are not needed to evaluate most knee complaints until after a period of conservative care and observation. In this case, the patient apparently has retained metal from lumbar surgery and is unable to have an MRI. The request for CT scan instead appears reasonable. The CT scan (left knee) is medically necessary and appropriate.

**Walker:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITIES GUIDELINES - TWC KNEE AND LEG PROCEDURE SUMMARY.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) <Knee and Leb (Acute & Chronic) Walking aids (canes, crutches, braces, orthoses, & walkers) Recommended, as indicated below. Almost half of patients with knee pain possess a walking aid. Disability, pain, and age-related impairments seem to determine the need for a walking aid. Nonuse is associated with less need, negative outcome, and negative evaluation of the walking aid. (Van der Esch, 2003) There is evidence that a brace

has additional beneficial effect for knee osteoarthritis compared with medical treatment alone, a laterally wedged insole (orthosis) decreases NSAID intake compared with a neutral insole, patient compliance is better in the laterally wedged insole compared with a neutral insole, and a strapped insole has more adverse effects than a lateral wedge insole. (Brouwer-Cochrane, 2005) Contralateral cane placement is the most efficacious for persons with knee osteoarthritis. In fact, no cane use may be preferable to ipsilateral cane usage as the latter resulted in the highest knee moments of force, a situation which may exacerbate pain and deformity. (Chan, 2005) While recommended for therapeutic use, braces are not necessarily recommended for prevention of injury. (Yang, 2005) Bracing after anterior cruciate ligament reconstruction is expensive and is not proven to prevent injuries or influence outcomes. (McDevitt, 2004) Recommended, as indicated below. Assistive devices for ambulation can reduce pain associated with OA. Frames or wheeled walkers are preferable for patients with bilateral disease. (Zhang, 2008) While foot orthoses are superior to flat inserts for patellofemoral pain, they are similar to physical therapy and do not improve outcomes when added to physical therapy in the short-term management of patellofemoral pain. (Collins, 2008) In patients with OA, the use of a cane or walking stick in the hand contralateral to the symptomatic knee reduces the peak knee adduction moment by 10%. Patients must be careful not to use their cane in the hand on the same side as the symptomatic leg, as this technique can actually increase the knee adduction moment. Using a cane in the hand contralateral to the symptomatic knee might shift the body's center of mass towards the affected limb, thereby reducing the medially directed ground reaction force, in a similar way as that achieved with the lateral trunk lean strategy described above. Cane use, in conjunction with a slow walking speed, lowers the ground reaction force, and decreases the biomechanical load experienced by the lower limb. The use of a cane and walking slowly could be simple and effective intervention strategies for patients with OA. In a similar manner to which cane use unloads the limb, weight loss also decreases load in the limb to a certain extent and should be considered as a long-term strategy, especially for overweight individuals. (Reeves, 2011) See also U-Step walker.

**Decision rationale:** The patient presents with chronic pain of the lumbar spine and left knee pain. The provider requests for a walker to assist ambulation. The 07/22/14 utilization review states that treatment reports provided note that the patient is already using a walker and there was inadequate documentation to support the need for an additional aid. The 07/17/14 report by [REDACTED] notes the patient is using the walker of his neighbor. ODG guidelines state the following about walking aids (canes, crutches, braces, orthoses, and walkers), "Recommended, as indicated below. Almost half of patients with knee pain possess a walking aid. Disability, pain, and age-related impairments seem to determine the need for a walking aid. Nonuse is associated with less need, negative outcome, and negative evaluation of the walking aid." " Frames or wheeled walkers are preferable for patients with bilateral disease. (Zhang, 2008)". In this case, the patient has difficulty with ambulation and appears to be a risk for fall. Use of walker appears medically indicated. The Walker is medically necessary and appropriate.