

<b>Case Number:</b>	CM14-0216331		
<b>Date Assigned:</b>	01/06/2015	<b>Date of Injury:</b>	07/01/2011
<b>Decision Date:</b>	02/28/2015	<b>UR Denial Date:</b>	12/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/24/2014

### 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. 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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & Gen Prev Med

### 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 female worker with a work related injury dated May 20, 2011. At the physician's visit dated December 26, 2014, the worker was complaining of neck and low back pain. Pain was reported to be the same as with previous visits and was rated six on a scale of ten, pain interfered with her daily activity and sleep. Treatment had included Norco two times per day as needed and the worker reported good relief with the medication. The physician documented there was no change in condition since the visit dated November 21, 2014. Physical exam was remarkable for paracervical muscle tenderness, paravertebral muscle tenderness in the low lumbar regions and straight leg raises were negative. Diagnoses at that visit included neck pain with radicular symptoms to the upper extremities, more on the left side, low back pain with radicular symptoms to the lower extremities, more of the right side and magnetic resonance imaging findings of disc protrusions at the L3-4, L4-5 and L5-S1 as well as an annular tear at the L5-S1. The utilization review decision dated December 16, 2014 non-certified the request for a magnetic resonance imaging of the bilateral knees and DME request for a right lateral heel wedge. The rationale for the non-coverage of the bilateral knees was based on the California MTUS and the ODG. The guidelines indicated unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment. The physical therapy note dated 10/30/2014 revealed that the patient's knee range of motion had improved drastically since previous visit, therefore the most recent progress notes did not indicate any subjective or objective findings that meet criteria and there

are no previous films. The worker did not have a documented progression of a neurologic deficit and the request was therefore non-certified. The rationale for non-coverage of the right lateral heel wedge was based on the CA MTUS and the ODG. The worker had significant lower back, bilateral knee and neck pain but there was no documentation to support the necessity for a heel wedge. Documentation did not provide any evidence of leg length discrepancy, plantar fasciitis or Achilles tendonitis, therefore the request for a right lateral heel wedge was non-certified as not medically necessary.

## **IMR ISSUES, DECISIONS AND RATIONALES**

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

**MRI bilateral knee:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee & Leg (Acute & Chronic)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341-343. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, MRIs (magnetic resonance imaging)

**Decision rationale:** ACOEM notes Special studies are not needed to evaluate most knee complaints until after a period of conservative care and observation and reliance only on imaging studies to evaluate the source of knee symptoms may carry a significant risk of diagnostic confusion (false-positive test results) because of the possibility of identifying a problem that was present before symptoms began, and therefore has no temporal association with the current symptoms. The treating physician does not detail the failure of conservative treatment or the treatment plan for the patient's knee. ODG further details indications for MRI:- Acute trauma to the knee, including significant trauma (e.g, motor vehicle accident), or if suspect posterior knee dislocation or ligament or cartilage disruption.- Nontraumatic knee pain, child or adolescent: nonpatellofemoral symptoms. Initial anteroposterior and lateral radiographs nondiagnostic (demonstrate normal findings or a joint effusion) next study if clinically indicated. If additional study is needed.- Nontraumatic knee pain, child or adult. Patellofemoral (anterior) symptoms. Initial anteroposterior, lateral, and axial radiographs nondiagnostic (demonstrate normal findings or a joint effusion). 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 (demonstrate normal findings or a joint effusion). If additional studies are indicated, and if internal derangement is suspected.- Nontraumatic knee pain, adult - nontrauma, nontumor, nonlocalized 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)The treating physician has not provided documentation that indicates subjective or objective findings that would warrant an MRI of this patient's bilateral knees at this time. The medical documentation provided does not include x-

rays or other first line testing that would indicate the need for an MRI. The request is not medically necessary.

**Right lateral heel wedge:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Ankle & Foot (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) Ankle and Foot, Heel Pad

**Decision rationale:** ODG states Recommended as an option for plantar fasciitis, but not for Achilles tendonitis. Plantar fasciitis: This RCT concluded that a silicone insole should be considered a first-line treatment option in patients with plantar fasciitis. (Yucel, 2013) This RCT found stretching and heel pads the most effective treatments for plantar fasciitis, with silicone inserts showing the largest percentage improvement. As part of the initial treatment of proximal plantar fasciitis, when used in conjunction with a stretching program, a prefabricated shoe insert is more likely to produce improvement in symptoms than a custom polypropylene orthotic device or stretching alone. The percentages improved in each group were: (1) silicone insert, 95%; (2) rubber insert, 88%; (3) felt insert, 81%; (4) Achilles tendon and plantar fascia stretching only, 72%; and (5) custom orthosis, 68%. (Pfeffer, 1999). Achilles tendonitis: There is little information available from trials to support the use of heel pads in the treatment of acute or chronic Achilles tendinitis. (McLauchlan-Cochrane, 2002). The treating physician has not provided documentation of leg length discrepancy, plantar fasciitis, or Achilles tendinitis to meet the guidelines for a heel wedge at this time.