

<b>Case Number:</b>	CM15-0125272		
<b>Date Assigned:</b>	07/09/2015	<b>Date of Injury:</b>	09/23/2008
<b>Decision Date:</b>	08/12/2015	<b>UR Denial Date:</b>	06/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/29/2015

### 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 58 year old female, who sustained an industrial injury on 9/23/2008. Diagnoses include lumbar spondylosis and facet arthropathy, lumbar degenerative disc disease with herniated nucleus pulposus, lumbar radiculopathy, myospasm and myofascial trigger points, left wrist pain, left knee pain, depression secondary to chronic pain, left sacroiliitis with severe flare up left gluteal bursitis and plantar fasciitis left heel. Treatment to date has consisted of conservative measures including medications, injections, home exercise, physical therapy and bracing. Per the Primary Treating Physician's Progress Report dated 6/12/2015, the injured worker reported low back pain radiating to the left buttock and left lower extremity posteriorly. She has severe acute pain in the left side of her low back in the area of the sacroiliac joint as well as in her left gluteal region. She also reported continued left heel pain, tightness in her mid and low back, left knee pain, bilateral hand pain and occasional heartburn causing chest pain. Physical examination of the left wrist revealed pain with range of motion. Lumbar spine examination revealed significant pain with extension beyond neutral and rotation of the lumbar spine to the left. She reported tightness with forward flexion at 50 and low back pain with lateral flexion at 25 in each direction. She had pain with extension to 20 and with facet loading bilaterally, left much greater than right. She had palpable muscle spasm and myofascial trigger points with twitch response and referral of pain. Left knee exam revealed painful range of motion. The plan of care included continuation of physical therapy, follow-up care, diagnostics and medications, and authorization was requested for magnetic resonance imaging (MRI) of the left knee, ibuprofen 800mg #60 and Omeprazole 20mg #60.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI of the left knee:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341, 342. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg (acute and chronic) Chapter, under Magnetic resonance imaging.

**Decision rationale:** Based on the 06/12/15 progress report provided by treating physician, the patient presents with low back that radiates to the left lower extremity and left knee pain. The request is for MRI of the left knee. Patient's diagnosis per RFA dated 06/12/15 included lumbar/lumbosacral sacroiliitis and depressive disorder. Diagnosis on 06/12/15 included left knee pain, lumbar radiculopathy and plantar fasciitis of the left heel. Physical examination on 06/12/15 revealed pain to left knee with range of motion. Treatment to date has included imaging studies, injections, home exercise, physical therapy, lumbar support and medications. Patient's medications include Vicodin, Ibuprofen, Tizanidine, Duexis and Omeprazole. The patient may return to modified work duty, per 06/12/15 report. Treatment reports provided from 01/23/12 - 06/12/15. ACOEM Guidelines page 341 and 342 on MRIs of the knee state that special studies are not needed to evaluate post knee complaints until after a period of conservative care and observation. Most knee problems improve quickly once any red flag issues are ruled out. For patients with significant hemarthrosis and history of acute trauma, radiography is indicated to evaluate for fracture. ODG-TWC, Knee and Leg (acute and chronic) Chapter, under Magnetic resonance imaging states: "soft tissue injuries (meniscal, chondral injuries, and ligamentous disruption) are best evaluated by an MRI. MRI is reasonable if internal derangement is suspected. 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." Treater has not provided medical rationale for the request. MRI of the left knee dated 01/23/12 revealed "negative study." Per UR letter dated 06/24/15, patient had MRI study of the left knee on 03/15/10. The patient continues with pain to left knee, and treater requests what appears to be the third MRI study. Guidelines support knee MRI when there is suspicion of internal derangement. In this case, there is no discussion of acute re-injury or red flag physical exam findings for the left knee. Repeat MRI's are supported by ODG "To assess knee cartilage repair tissue" post-surgically, or in cases of re-injury to the joint. Just the persistence of intractable pain to the joint and tenderness to palpation does not warrant additional imaging. This request is not in accordance with guidelines. Therefore, the request is not medically necessary.

**Omeprazole 20 mg, sixty count:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 69.

**Decision rationale:** Based on the 06/12/15 progress report provided by treating physician, the patient presents with low back that radiates to the left lower extremity and left knee pain. The request is for Omeprazole 20 mg, sixty count. Patient's diagnosis per RFA dated 06/12/15 included lumbar/lumbosacral sacroiliitis and depressive disorder. Diagnosis on 06/12/15 included left knee pain, lumbar radiculopathy and plantar fasciitis of the left heel. Physical examination on 06/12/15 revealed pain to left knee with range of motion. Treatment to date has included imaging studies, injections, home exercise, physical therapy, lumbar support and medications. Patient's medications include Vicodin, Ibuprofen, Tizanidine, Duexis and Omeprazole. The patient may return to modified work duty, per 06/12/15 report. Treatment reports provided from 01/23/12 - 06/12/15. MTUS pg 69 states, "Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA)." "Treatment of dyspepsia secondary to NSAID therapy: Stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI." Omeprazole and Ibuprofen were included in patient's medications, per progress reports dated 01/30/15, 05/13/15, and 06/12/15. The patient is on NSAID therapy and has reported "heartburn is causing some chest pain," per 06/12/15 report. MTUS allows for prophylactic use of PPI along with oral NSAIDs when appropriate GI risk is present. The request to continue PPI appears reasonable and in accordance with guidelines. Therefore, the request is medically necessary.