

Case Number:	CM13-0025306		
Date Assigned:	06/23/2014	Date of Injury:	06/04/2012
Decision Date:	08/07/2014	UR Denial Date:	09/05/2013
Priority:	Standard	Application Received:	09/17/2013

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 Occupational Medicine. 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 claimant was injured on 06/04/12 when she fell and an MRI of the left knee is under review. She was diagnosed with an internal derangement of the left knee. X-rays on 12/13/12 were unremarkable. At that time she had mild medial joint line tenderness and a mildly positive patella grind test and positive Apley's and McMurray's tests. She saw [REDACTED] on 05/20/13 for 7/10 left knee pain and 6/10 right knee pain. She also had 5/10 low back pain with left lower extremity symptoms, and left elbow, forearm, and wrist pain. Both knees were tender and she had crepitance. She was diagnosed with left knee traumatic chondromalacia patella. She had a recent MRI that showed possible meniscal tears in both knees. She saw [REDACTED] and reported anterior and medial knee pain bilaterally. It was increased with activity as well as kneeling, flexion, and pivoting but she had no locking or gross instability. She had occasional catching sensations. She had a brisk symmetric gait. Range of motion of both knees was 0-130. Both knees were stable with varus and valgus stress as well as Lachman's testing. She had mild medial joint line tenderness bilaterally. Lateral joint lines were nontender and there were no effusions. She had a mildly positive patellar grind test bilaterally and positive Apley's test and negative McMurray's test. X-rays showed well-maintained joint spaces. She saw [REDACTED] on 08/13/13 and complained of left knee and low back pain. She stated that she had an MRI of the left knee but he had never seen it. It had not been sent to him. Her symptoms were substantially worse since a prior left knee MRI scan. Her left knee symptoms had gotten worse since last MRI. MRIs of the knees reportedly revealed medial meniscus tears that were degenerative without significant displacement. Exam of the left knee showed medial and lateral joint line tenderness with some patellofemoral compression pain. MRIs were ordered. The reading on the prior MRI scans demonstrated medial meniscus tears that were degenerative. Nonsurgical treatment had been recommended. She was diagnosed with left knee

progressive internal derangement and a repeat scan of the left knee was ordered. An MRI of the low back was also recommended.

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 without contrast: 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): table 13-5.

Decision rationale: The history and documentation do not objectively support the request for a repeat MRI in the absence of clear evidence of new or progressive focal deficits and/or failure of a reasonable course of conservative treatment for worsening symptoms. The MTUS state in Table 13-5 that MRI may be used to evaluate internal derangements but "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 specific indication for this study has not been clearly described and none can be ascertained from the records. The claimant reports worsening pain but there is no documentation of new or worsening findings on physical examination. The left knee is not unstable and a diagnosis of patellofemoral syndrome has been made clinically. It is not clear whether there has been a significant change in her condition such that a repeat study is necessary. It is also not clear how the results of this study may change the claimant's course of treatment. The medical necessity of this study has not been demonstrated.