

Case Number:	CM13-0034467		
Date Assigned:	11/04/2013	Date of Injury:	02/01/2010
Decision Date:	05/02/2014	UR Denial Date:	09/27/2013
Priority:	Standard	Application Received:	10/15/2013

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Management, 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 57 year old female who was injured on 09/16/1991 through 01/31/2010. Mechanism of injury is unknown. She stated she had right leg pain that had been going on for more than two months. Prior treatment history has included a left knee arthroscopy with meniscectomy and debridement on 07/06/2006. Diagnostic studies reviewed include MRI of the left knee dated 08/30/2007 which showed moderate to severe degenerative arthritic changes, a small to moderate left knee joint effusion and interval partial meniscectomy. A right knee x-ray dated 10/23/2007 showing diffuse osteopenia and degenerative changes. On 03/28/2010 a right knee x-ray showed degenerative joint disease with no significant interval change compared to prior study 10/23/2007. Bilateral knee x-rays dated 07/09/2010 showed mild to moderate degree of degenerative change involving the lateral and medial compartment with mild narrowing of the medial joint spaces bilaterally. On 09/27/2011 an MRI of the right knee showed there is a longitudinal horizontal tear involving the posterior horn and body of medial meniscus with moderate extrusion of the medial meniscal body. There is mild degenerative signal throughout lateral meniscus and marked tri-compartmental osteoarthritis. A left knee x-ray dated 09/18/2003 which showed degenerative changes at the patella. PR-2 dated 12/18/2013 documented the patient to have complaints bilateral knee pain. She has not undergone any type of therapy recently. She has been taking medication as prescribed. Objective findings on exam included well-healed arthroscopic holes were noted in the left knee. Joint line is tender to palpation. Positive McMurray's on the left. There was no right knee PE documented throughout the records provided. Prior PR-2s document same left knee findings.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI BILATERAL KNEES: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints
Page(s): 332-336.

Decision rationale: Per the Occupational Medicine Practice Guidelines, MRI of the knees is indicated for acute knee trauma or when initial plain anteroposterior and lateral radiographs are non-diagnostic. Additionally, routine post-surgical MRI imaging of the knee is not recommended. The medical records indicate no change in the patient's symptoms or physical examination. Given the unchanged status of her condition and no recent initial imaging or treatment, the request is non-certified.