

<b>Case Number:</b>	CM13-0063040		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	02/01/2010
<b>Decision Date:</b>	05/16/2014	<b>UR Denial Date:</b>	11/19/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/09/2013

### 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's medications as of 09/18/2013 include: (There was no VAS documented) Docusate Sodium 100 mg Omeprazole 20 mg Hydrocodone (Vicodin ES) APAP 7.5/750 mg Orphenadrine ER 100 mg Medrox Pain Relief Ointment Cidaflex tablets Diagnostic studies reviewed include x-rays of the bilateral knees, standing AP dated 07/09/2010, revealed a mild to moderate degree of degenerative change involving the lateral, medial compartment with mild narrowing of the medial joint spaces bilaterally, slightly more on the left than the right. There was no convincing x-ray evidence of acute fracture seen on this examination. PR2 dated 12/18/2013 and 10/16/2013 stated the patient claimed her symptoms persisted. She continued to have pain in her neck, back, bilateral shoulders, and wrists. She also complained of bilateral knee pain. On examination of the left knee, she had well-healed arthroscopic holes noted in the left knee. The joint line was tender to palpation and positive McMurray's on the left. Visit note dated 09/18/2013 reported the patient received a diagnosis of brachial neuritis or radiculitis, carpal tunnel syndrome, shoulder impingement, and lumbar radiculopathy. There was no physical examination documented for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MAGNETIC RESONANCE IMAGING OF THE RIGHT KNEE:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints  
Page(s): 341-343.

**Decision rationale:** The Expert Reviewer's decision rationale: As per the CA MTUS guidelines, "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." As per the ODG, MRI of the knee is recommended if internal derangement is suspected. The medical records submitted for review indicates that this patient has bilateral knee pain but there is no documentation of right knee physical exam. Additionally, the prior treatment to the right knee is unclear such as trial and failure of physical therapy. Thus, the request is not certified.

**MAGNETIC RESONANCE IMAGING OF THE LEFT KNEE:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints  
Page(s): 341-343.

**Decision rationale:** As per the CA MTUS guidelines, "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." As per the ODG, MRI of the knee is recommended if internal derangement is suspected. The medical records submitted for review indicates that this patient has had left knee arthroscopic surgery in July 2006 and was treated with physical therapy. The request for MRI of the left knee was due to exacerbation of symptoms, but the medical records indicate no worsening or progression of the symptoms. The physical exam of the left knee was limited with only documentation of joint line tenderness and positive McMurray on the left; however, there is no documentation of ROM loss, joint effusion, gait abnormalities, or any functional limitations. Additionally, it is unclear if the surgery is considered as an option. Thus, the medical necessity has not been established and the request is non-certified.