

<b>Case Number:</b>	CM14-0100272		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	06/25/2010
<b>Decision Date:</b>	10/28/2014	<b>UR Denial Date:</b>	06/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/30/2014

### 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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in Arizona. 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:

This 44-year-old male banquet server and bar tender noted that he experienced back pain initially in 2004 due, in his opinion, to repetitive motion of forward bending. In 2005 he had an exacerbation of pain when lifting an ice bucket, slipped and fell. After reporting the incident he was given pain medication by a physician. He was not referred to a clinic or hospital. He worked from 2005 to 2010 in pain. On June 25, 2010 he was let go without explanation. He last worked on June 25, 2010. His day of injury designated as 6/26/2010. He continued to have symptoms and was seen by a chiropractor and his physician for treatment for his low back pain including manipulations (10-12 sessions), medications, injections and later recommended surgery. He stopped working when he had stomach surgery in 2009. After termination, he had lumbar back surgery and then decided to get a lawyer. His medical major clinical problems were initially related to back pain (failed back syndrome), mental issues, family history of gastric cancer for which he underwent prophylactic gastrectomy, borderline diabetes mellitus, irritable bowel syndrome and recent-onset (5/17/2012) of worsening knee-related complaints. His psychiatric history was reviewed but not included in this summary. The first mention of knee-related problem was on 5/17/2012 ("Sprain of knee and leg") under "Diagnosis" from the limited documentation of that problem. Treating physician mentions no knee-related specific symptoms until 7/22/2014 when he reported the patient noticed a decreased range of knee motion in flexion and extension, catching and locking sensation in the knee as well as a sensation of instability. He walked with an antalgic gait and rated his left knee pain as 5-6/10 (pain scale). Physical examination since then revealed patellar crepitation, tenderness medial and lateral joint space left knee and positive McMurray test on examination. No clinical documentation of specific treatment regime for knee-related complaints was found. Treatment specific to the knee was not documented. Documentation of physiotherapy / pain management for the knee was not available.

Pain medications given for other pathology did obviously also benefit the knee pain complaint. Diagnostic studies for knee-related symptoms were not documented. CT scan of the left knee was requested as well as a walker. Diagnosis was documented as knee and leg strain on 8/14/2014 and meniscal pathology on 5/21/2014. Primary diagnosis was thoracic/lumbo-sacral neuritis/radiculopathy unspecified. Recommendation: CT scan of the left knee (7/17/2014). Work status: Out of work at present. UR denial date was 6/20/2014. UR decision was to deny request.

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

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

**CT scan of left knee:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG Knee), Computed tomography/CT knee

**Decision rationale:** Documentation is very limited in this case. No chronological history or clinical documentation beyond "sprain of knee or possible meniscal injury." MTUS show [Table 13.5] that documentation of a clear history and clinical picture is a more accurate diagnostic entity than imaging studies to identify and diagnose knee pathology. This patient also does not present any red flags. According to MTUS, relying on imaging studies can also increase false positive rates as explained. CT-scan of the knee has a low probability to identify anatomic defects or assist in diagnosis of clinically significant pathology. As shown in the table, MRI can play a more significant role in diagnostic work-up. MRI was not prescribed due to residual metal implant[s] after spine surgery. ODG states CT to be an option for continued pain after total knee arthroplasty with negative radiographs in diagnostic work-up of implant loosening and in work-up for osteolysis of bone, CT was found to be superior to plain radiographs. In addition it can aid in assessment of rotational alignment of the femoral component and in detecting subtle or occult peri-prosthetic fractures. None of these scenarios were actually present in this patient. Also, in patients with non-acute knee symptoms who are highly suspected clinically of having intra-articular knee abnormality, magnetic resonance imaging should be performed to exclude the need for arthroscopy. The request is not medically necessary.