MAXIMUS Federal Services

Case Number:	CM14-0104917		
Date Assigned:	07/30/2014	Date of Injury:	04/19/2012
Decision Date:	09/25/2014	UR Denial Date:	06/17/2014
Priority:	Standard	Application Received:	07/07/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine 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 presents with pain in his left knee, worse by prolonged walking, standing or bending his left knee. The patient describes his pain as aching and stabbing. There are swelling in medial aspect of the patient's left knee and tenderness over medial and lateral joint line. The patient rates his pain as 7-9/10 on the pain scale, depending on the intake of pain medication. According to [redacted] report on 06/05/2014, diagnostic impressions are: 1) Left knee pain 2) S/P arthroscopy surgery of left knee on 07/24/2012 3) Chronic pain syndrome 4) Osteoarthritis of left knee The utilization review determination being challenged is dated on 06/17/2014. [redacted] is the requesting provider, and he provided treatment reports from 01/27/2014 to 07/17/2014.

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: Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG-TWC guidelines (http://www.odg-twc.com/odgtwc/low_back.htm#Protocols) has the

following:Recommended for indications below. MRI's are test of choice for patients with prior back surgery. Repeat MRI's are indicated only if there has been progression of neurologic deficit. (Bigos, 1999) (Mullin, 2000) (ACR, 2000) (AAN, 1994) (Aetna, 2004) (Airaksinen, 2006) Magnetic resonance imaging has also become the mainstay in the evaluation of myelopathy. An important limitation of magnetic resonance imaging in the diagnosis of myelopathy is its high sensitivity. The ease with which the study depicts expansion and compression of the spinal cord in the myelopathic patient may lead to false positive examinations and inappropriately aggressive therapy if findings are interpreted incorrectly. (Seidenwurm, 2000) There is controversary over whether they result in higher costs compared to X-rays including all the treatment that continues after the more sensitive MRI reveals the usual insignificant disc bulges and herniations. (Jarvik-JAMA, 2003) In addition, the sensitivities of the only significant MRI parameters, disc height narrowing and anular tears, are poor, and these findings alone are of limited clinical importance. (Videman, 2003) Imaging studies are used most practically as confirmation studies once a working diagnosis is determined. MRI, although excellent at defining tumor, infection, and nerve compression, can be too sensitive with regard to degenerative disease findings and commonly displays pathology that is not responsible for the patient's symptoms. With low back pain, clinical judgment begins and ends with an understanding of a patient's life and circumstances as much as with their specific spinal pathology. (Carragee, 2004) Diagnostic imaging of the spine is associated with a high rate of abnormal findings in asymptomatic individuals. Herniated disk is found on magnetic resonance imaging in 9% to 76% of asymptomatic patients; bulging disks, in 20% to 81%; and degenerative disks, in 46% to 93%. (Kinkade, 2007) See also ACR Appropriateness Criteria. See also Standing MRI.Indications for imaging Magnetic resonance imaging: Thoracic spine trauma: with neurological deficit. Lumbar spine trauma: trauma, neurological deficit. Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit). Uncomplicated low back pain, suspicion of cancer, infection. Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit. (For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383.) (Andersson, 2000)- Uncomplicated low back pain, prior lumbar surgery- Uncomplicated low back pain, cauda equina syndrome- Myelopathy (neurological deficit related to the spinal cord), traumatic- Myelopathy, painful- Myelopathy, sudden onse.

Decision rationale: The patient presents severe pain in his left knee. The patient is s/p left knee arthroscopy. The request is for MRI of the left knee. Utilization review letter on 06/17/2014 indicates that as a result of MRI on 04/30/2012, the patient underwent left knee arthroscopy, debridement of meniscal tear, chondroplasty, and removal of loose body or ganglion cyst on 07/24/2012. The patient had X-ray on 05/23/2013 (AME report on 12/09/2014 indication) or 11/05/2013 (Utilization review indication) which reveals mild medial compartment narrowing, subluxations of the tibia relative to the femur, and tricompartmental spurring. MTUS guidelines do not discuss MRI. ODG guidelines do not recommend it unless there is soft-tissue injuries such as meniscal, chondral surface injuries, and ligamentous disruption. ODG does support it for post-operative evaluation of cartilage repair. Given that this patient had chondroplasty with persistent symptoms, an updated MRI appears supported. Therefore, this request is medically necessary.