MAXIMUS Federal Services

Case Number:	CM14-0200730		
Date Assigned:	12/11/2014	Date of Injury:	11/15/2010
Decision Date:	01/30/2015	UR Denial Date:	10/30/2014
Priority:	Standard	Application Received:	12/01/2014

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 Internal Medicine 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 an injured worker with knee complaints. Date of injury was November 15, 2010. The primary treating physician's permanent and stationary report for the lumbar spine, right knee, right shoulder dated June 17, 2014 documented that from an orthopedic perspective he has reached maximal medical improvement. The patient continues to have ongoing pain about his right greater than left knee. He also has pain radiating in his back down his left leg, and he has difficulty going from a bent to standing position. When riding in a car he does feel pain and stiffness in his left back. Getting out of a car is somewhat difficult due to the limited motion of his right knee. Physical examination was documented. The right knee exam demonstrates a healed midline incision. He flexes to 140 degrees and fully extends. The ligamentous exam is normal. There is no effusion or crepitance. He ambulates with a nonantalgic gait. Diagnoses were status post right total knee replacement, status post lumbar laminectomy, and status post right shoulder arthroscopic subacromial decompression with partial distal claviculectomy. The patient was considered having reached maximal medical improvement and permanent and stationary. MRI magnetic resonance imaging of the left knee dated 8/27/2013 demonstrated multifocal areas of bone marrow edema related to areas of focal irregular cartilaginous thinning superimposed upon a more diffuse and generalized mild to moderate chondromalacia, most notable in the medial and patellofemoral compartments. No cruciate or collateral ligament pathology was noted. Possible tiny nondisplaced tear surfacing about inferior articulating surface, posterior horn, medial meniscus, red zone was noted. Anterior and posterior cruciate ligaments are intact and normal in signal. Medial and lateral collateral ligament complexes are intact and of normal signal. Quadriceps and patellar tendons are intact and of normal signal. Musculature about the knee identified to be normal in signal and bulk. This includes normal popliteal tendon and muscle belly. No effusion was noted. No synovitis or loose bodies was

noted. Lateral meniscus was normal. No visible tear or significant degeneration of the lateral meniscus was noted. Medial meniscus demonstrated a focal, linear, area of signal abnormality exiting inferior articulating surface of the red zone of the posterior horn medial meniscus likely represents a nondisplaced tear. This is small focal abnormality. The primary treating physician consultation report dated September 30, 2014 documented subjective complaints of left knee pain. Physical examination demonstrated slight crepitance throughout range of motion with a positive McMurray test medially. No effusion was noted. Negative varus/valgus laxity, Lachman, and pivot shift test were reported. Diagnosis was left knee pain. The physician recommended a repeat MRI scan of the left knee.

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: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 335-336, 341, 343-345, 346-347.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses MRI (magnetic resonance imaging). The American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) states that special studies are not needed to evaluate most knee complaints until after a period of conservative care and observation. Reliance only on imaging studies to evaluate the source of knee symptoms may carry a significant risk of diagnostic confusion (false-positive test results). An MRI test is indicated only if surgery is contemplated. The ACOEM Table 13-6 indicates that an MRI is recommended to determine extent of ACL anterior cruciate ligament tear preoperatively. Table 13-6 does not recommend MRI for other knee conditions.Medical records document that MRI (magnetic resonance imaging) of the left knee was performed on August 27, 2013 approximately one year prior. The 8/27/13 MRI of the left knee demonstrated multifocal areas of bone marrow edema related to areas of focal irregular cartilaginous thinning superimposed upon a more diffuse and generalized mild to moderate chondromalacia, most notable in the medial and patellofemoral compartments. No cruciate or collateral ligament pathology was noted. Possible tiny non-displaced tear surfacing about inferior articulating surface, posterior horn, medial meniscus, red zone was noted. Anterior and posterior cruciate ligaments are intact and normal in signal. Medial and lateral collateral ligament complexes are intact and of normal signal. Quadriceps and patellar tendons are intact and of normal signal. Musculature about the knee identified to be normal in signal and bulk. This includes normal popliteal tendon and muscle belly. No effusion was noted. No synovitis or loose bodies was noted. Lateral meniscus was normal. No visible tear or significant degeneration of the lateral meniscus was noted. Medial meniscus demonstrated a focal, linear, area of signal abnormality exiting inferior articulating surface of the red zone of the posterior horn medial meniscus likely represents a non-displaced tear. This is small focal abnormality. The primary treating physician consultation report dated September 30, 2014 documented that the physical examination demonstrated slight crepitance throughout range of motion with a positive

McMurray test medially. No effusion was noted. Negative varus/valgus laxity, Lachman, and pivot shift test were reported. Diagnosis was left knee pain. A repeat MRI scan of the left knee was requested. The 9/30/14 progress report did not document acute trauma or recent plain-film radiographs of the left knee. No red flags were documented in the 9/30/14 progress report. The medical records do not support for the request for a repeat left knee MRI. Therefore, the request for MRI of the left knee is not medically necessary.