

Case Number:	CM14-0208393		
Date Assigned:	12/22/2014	Date of Injury:	07/24/2010
Decision Date:	02/28/2015	UR Denial Date:	12/03/2014
Priority:	Standard	Application Received:	12/12/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Texas, California
 Certification(s)/Specialty: Family Practice

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 is a 71 year old female patient who sustained a work related injury on 7/24/10 and/or 7/24/14. Patient sustained the injury when she hit by a dog. The current diagnoses include left knee derangement and localized osteoarthritis of the lower leg. Per the doctor's note dated 11/06/14, patient has complaints of pain and swelling in both of her knees and pain in the left knee and episodic catching/locking and subsequent effusion. Physical examination revealed swelling noted of the left knee, ROM 5-115 degrees, lateral joint line tenderness and positive bounce testing. The current medication lists include oxycodone and oxycontin. The patient has had X-ray and MRI for this injury. A X-ray of the left knee on 12/5/13 revealed advanced medial compartment osteoarthritis with subchondral sclerosis, and mild osteophytes and reduction of joint clear space in weight bearing; x-rays of the right knee on 7/12/11, that revealed the findings of a post total knee arthroplasty procedure; a left knee MRI on 6/13/11 that showed extensive medial meniscal pathology and the lateral meniscus medial compartment and some lateral compartment and patellofemoral arthritis with effusion. Diagnostic imaging reports were not specified in the records provided. The patient's surgical history include total knee arthroplasty of the, right knee. The patient has received an unspecified number of PT visits for this injury.

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 (ODG), Knee & Leg (Acute & Chronic)

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

Decision rationale: Per the ACOEM guidelines cited above, "Special studies are not needed to evaluate most knee complaints until after a period of conservative care and observation. Most knee problems improve quickly once any red flag issues are ruled out. For patients with significant hemarthrosis and a history of acute trauma, radiography is indicated to evaluate for fracture." A X-ray of the left knee on 12/5/13 revealed advanced medial compartment osteoarthritis with subchondral sclerosis, and mild osteophytes and reduction of joint clear space in weight bearing; a left knee MRI on 6/13/11 that showed extensive medial meniscal pathology and the lateral meniscus medial compartment and some lateral compartment and patellofemoral arthritis with effusion. Any significant changes in objective physical examination findings since the last MRI that would require a repeat MRI study were not specified in the records provided. Any of these indications for knee MRI were not specified in the records provided. A detailed knee exam including tests for internal derangement like the Mc Murrays test, anterior drawer test and tests for instability were not specified in the records provided. Patient has received an unspecified number of PT visits for this injury. The records submitted contain no accompanying current PT evaluation for this patient. Previous conservative therapy notes were not specified in the records provided. Patient did not have abnormal findings in the physical examination suggestive of significant internal derangement. The history or physical examination findings do not indicate pathology including cancer, infection, or other red flags. A recent left knee X-ray report is not specified in the records provided. A plan for an invasive procedure of the left knee was not specified in the records provided. The rationale for a left knee MRI was not specified in the records provided. The medical necessity of the request for MRI left knee is not fully established in this patient.