

Case Number:	CM15-0160254		
Date Assigned:	08/26/2015	Date of Injury:	04/13/2009
Decision Date:	10/02/2015	UR Denial Date:	08/13/2015
Priority:	Standard	Application Received:	08/17/2015

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: California, District of Columbia, Maryland
Certification(s)/Specialty: Anesthesiology, Pain Management

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 injured worker is a 58 year old male who sustained an industrial-work injury on 4-13-09. He reported an initial complaint of neck, mid back, low back, and left knee pain. The injured worker was diagnosed as having left knee arthroscopy, rule out internal derangement pathology, cervical spine sprain-strain, rule out cervical radiculopathy, thoracic sprain-strain, lumbar sprain-strain and rule out lumbar intradiscal component; and stress, insomnia, and anxiety. Treatment to date includes medication, surgery (left knee arthroscopy), physical therapy, and acupuncture. MRI results were reported on 11-2-13. X-ray results were reported on 12-2-13. EMG-NCV (electro-myography and nerve conduction velocity test) was done on 2-17-11 and 8-11-14. Currently, the injured worker complained of cervical, lumbar, and left knee pain. Per the primary physician's report (PR-2) on 7-21-15, exam of the left knee reveals effusion, tenderness to the medial and lateral aspect, range of motion at 0-90 degrees, crepitation, and positive McMurray's with use of a hinged brace. Cervical exam noted tenderness to the cervical spine and paraspinal musculature with spasms and decreased range of motion. Thoracic and lumbar spine note decreased range of motion and tenderness. The requested treatments include MRI left knee, cervical spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI left knee, cervical spine: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Neck and Upper Back, MRI. Online Edition.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg, MRI's (magnetic resonance imaging).

Decision rationale: Per the ODG guidelines regarding MRI of the knee: Recommended as indicated below. Soft-tissue injuries (meniscal, chondral surface injuries, and ligamentous disruption) are best evaluated by MRI. (ACR, 2001) See also ACR Appropriateness Criteria. Diagnostic performance of MR imaging of the menisci and cruciate ligaments of the knee is different according to lesion type and is influenced by various study design characteristics. Higher magnetic field strength modestly improves diagnostic performance, but a significant effect was demonstrated only for anterior cruciate ligament tears. (Pavlov, 2000) (Oei, 2003) A systematic review of prospective cohort studies comparing MRI and clinical examination to arthroscopy to diagnose meniscus tears concluded that MRI is useful, but should be reserved for situations in which further information is required for a diagnosis, and indications for arthroscopy should be therapeutic, not diagnostic in nature. Indications for imaging--MRI (magnetic resonance imaging): Acute trauma to the knee, including significant trauma (e.g, motor vehicle accident), or if suspect posterior knee dislocation or ligament or cartilage disruption. Non-traumatic knee pain, child or adolescent: non-patellofemoral symptoms. Initial anteroposterior and lateral radiographs non-diagnostic (demonstrate normal findings or a joint effusion) next study if clinically indicated. If additional study is needed. Non-traumatic knee pain, child or adult. Patellofemoral (anterior) symptoms. Initial anteroposterior, lateral, and axial radiographs non-diagnostic (demonstrate normal findings or a joint effusion). If additional imaging is necessary, and if internal derangement is suspected. Non-traumatic knee pain, adult. Non-trauma, non-tumor, non-localized pain. Initial anteroposterior and lateral radiographs non-diagnostic (demonstrate normal findings or a joint effusion). If additional studies are indicated, and if internal derangement is suspected. Non-traumatic knee pain, adult non-trauma, non-tumor, non-localized pain. Initial anteroposterior and lateral radiographs demonstrate evidence of internal derangement (e.g., Pellegrini Stieda disease, joint compartment widening). Repeat MRIs: Post-surgical if need to assess knee cartilage repair tissue. (Ramappa, 2007) Routine use of MRI for follow-up of asymptomatic patients following knee arthroplasty is not recommended. (Weissman, 2011) Per the medical records, the injured worker has not had an MRI in greater than one and a half years. Review of interval records reveals continuing decline in functionality. The injured worker has failed conservative treatment. The treatment plan is to rule out internal derangement including meniscal pathology. I respectfully disagree with the UR physician's assertion that the medical records do not support MRI of the left knee. The request is medically necessary. ACOEM guidelines support ordering of imaging studies for emergence of red flags, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient

evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. The documentation submitted for review does indicate upper extremity neurological component consistent with C6 and C7. I respectfully disagree with the UR physician's assertion that the medical records do not support MRI cervical spine. The request is medically necessary.