

Case Number:	CM15-0164974		
Date Assigned:	09/02/2015	Date of Injury:	06/13/2014
Decision Date:	10/06/2015	UR Denial Date:	08/10/2015
Priority:	Standard	Application Received:	08/24/2015

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: North Carolina

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:

The injured worker is a 42 year old male, who sustained an industrial injury on 6-13-14. The diagnoses have included left knee status post anterior cruciate ligament (ACL) revision reconstruction on 12-22-14. Treatment to date has included medications, activity modifications, off of work, work modifications, surgery, physical therapy, cane and other modalities. Currently, as per the physician progress note dated 7-1-15, the injured worker is status post left knee anterior cruciate ligament (ACL) revision reconstruction on 12-22-14 and has had a slow post-operative course. It is noted that he has been plagued with pain. He has had difficulty getting rid of his cane and has had difficulty with range of motion. The physician noted that he feel that the difficulty with range of motion has however, he still maintains the use of the cane. He is working modified duty and states that by the end of the shift he is in excruciating pain. He reports the onset of both low back pain and left lower extremity (LLE) pain. There is numbness, tingling and pain that emanate from the buttock and run down the left thigh and into the foot. The objective findings-physical exam of the left knee reveals well healed incisions, range of motion is 0 or full extension to about 130 degrees of flexion. He has difficulty with terminal flexion and feels a sense of tightness anteriorly over the knee. There is light touch sensation deficits noted in the L5 and S1 dermatomes. There is weakness in the gastrocsoleus on the left side as compared to the right. The physician notes that he is concerned that the injured worker is having this much difficulty this far from surgery and does not appear to be improving significantly at each successive visit. There are no previous diagnostic reports noted in the records. The physician requested treatment included Magnetic Resonance Imaging (MRI) of left knee.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of left knee: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341-343. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 11th Edition (Web), 2015, Knee and Leg (Acute and Chronic)/MRIs (magnetic resonance imaging).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 374.

Decision rationale: The ACOEM chapter on knee complaints states: 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. Reliance only on imaging studies to evaluate the source of knee symptoms may carry a significant risk of diagnostic confusion (false-positive test results) because of the possibility of identifying a problem that was present before symptoms began, and therefore has no temporal association with the current symptoms. Even so, remember that while experienced examiners usually can diagnose an ACL tear in the non-acute stage based on history and physical examination, these injuries are commonly missed or over-diagnosed by inexperienced examiners, making MRIs valuable in such cases. Also note that MRIs are superior to arthrography for both diagnosis and safety reasons. Table 13- 5 provides a general comparison of the abilities of different techniques to identify physiologic insult and define anatomic defects. The provided documentation for review and noted physical exam does not meet criteria for imaging per the ACOEM and the request is not certified and therefore is not medically necessary.