MAXIMUS Federal Services

Case Number:	CM15-0165075		
Date Assigned:	09/02/2015	Date of Injury:	05/19/2010
Decision Date:	10/06/2015	UR Denial Date:	08/05/2015
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 5-19-10. Initial complaint was of his left knee injury. The injured worker was diagnosed as having chronic pain, medial joint space left knee; symptomatic chondromalacia lateral facet left patella. Treatment to date has included status post left knee arthroscopic medial menisectomy and medial trochlear debridement (8-19-10); physical therapy; medications. Diagnostics studies included MRI left knee (6-3-10). Currently, the PR-2 notes dated 7-23-15 indicated the injured worker in the office on this date for evaluation, clinical findings and treatment recommendations. He complains of severe left knee pain rated at 7-8 out of 10. He describes the pain as intermittent, non-radiating associated with burning, throbbing, stabbing, aching and sharp pain along with tightness, stiffness and clicking-popping sensations. He has limited range of motion with flexion, rotation, stooping, bending, lifting, carrying, pushing, pulling, walking, standing, sitting, lying down, ascending, descending, stairs, squatting and kneeling. He is a status post left knee arthroscopic medial menisectomy and medial trochlear debridement on 8-19-10. He has also has three Euflexxa injections which he reports alleviated the pain temporarily. The treatment plan documents medications and baseline blood work to include liver and kidney function studies as well as baseline urine toxicology screening, a patella-stabilizing brace, and to continue with home exercise program. A MRI with gadolinium is requested due to symptoms of a possible re-tearing of the posterior horn of the medial meniscus with clicking noted, although McMurray's sign is not clinically noted. The provider is requesting authorization of MR Arthrogram of left knee.

IMR ISSUES, DECISIONS AND RATIONALES

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

MR Arthrogram of left knee: Upheld

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

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

Decision rationale: 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 nonacute 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.