

<b>Case Number:</b>	CM15-0166468		
<b>Date Assigned:</b>	09/04/2015	<b>Date of Injury:</b>	10/14/2013
<b>Decision Date:</b>	10/09/2015	<b>UR Denial Date:</b>	07/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/25/2015

### 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

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 58-year-old man sustained an industrial injury on 10-14-2013. The mechanism of injury is not detailed. Diagnoses include right wrist tenosynovitis, left sacroiliac sprain-strain, right carpal tunnel syndrome, right upper extremity myofascial pain syndrome, low back pain, and internal derangement of knee. Treatment has included oral medications. Physician notes on a PR-2 dated 7-24-2015 show complaints of chronic cervical spine pain with radiation to the right shoulder and arm, lumbar spine pain with radiation to the bilateral buttocks and thighs, right hand pain, and left knee pain with popping and giving way. Recommendations include left knee MRI, lumbar medial branch blocks, physical therapy, cervical spine transforaminal epidural steroid injections, possible surgical intervention, and follow up in six weeks.

### 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 without Contrast:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Knee Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Knee Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter, under MRI's.

**Decision rationale:** The patient was injured on 10/14/13 and presents with pain in his cervical spine, lumbar spine, right hand, and left knee. The request is for a MRI OF THE LEFT KNEE WITHOUT CONTRAST. The utilization review rationale is that "there is no documentation of non-diagnostic left knee anteroposterior and lateral radiographs, as required per cited guidelines." The RFA is dated 07/24/15 and the patient is not yet permanent and stationary. Review of the reports provided does not indicate if the patient had a prior MRI of the left knee. MTUS/ACOEM Guidelines Chapter 13, Knee Complaints Chapter under Special Studies Section, pages 341 and 342 states that special studies are not needed to evaluate post knee complaints until after a period of conservative care and observation. Mostly, problems improve quickly once any of the chronic issues are ruled out. For patients with significant hemarthrosis and history of acute trauma, radiography is indicated to evaluate their fracture. ODG Guidelines, Knee and Leg Chapter, under MRI's recommends MRIs for acute trauma and non-traumatic cases as well. ODG states that an MRI best evaluates soft tissue injuries (meniscal, chondral injuries, and ligamentous disruption). The patient has tenderness on palpation along the medial joint line and patella, a 2+ effusion in the left knee joint, and a positive Apley's compression test. He is diagnosed with right wrist tenosynovitis, left sacroiliac sprain-strain, right carpal tunnel syndrome, right upper extremity myofascial pain syndrome, low back pain, and internal derangement of knee. Treatment to date includes oral medications. Review of the reports provided does not indicate if the patient has had a prior MRI of the left knee. Given the patient's persistent level of symptoms and no prior MRI of the left knee, a MRI appears medically reasonable and supported by the guidelines. The request IS medically necessary.