Case Number:	CM15-0182681		
Date Assigned:	09/23/2015	**Date of Injury:**	06/25/2000
Decision Date:	10/30/2015	**UR Denial Date:**	09/01/2015
Priority:	Standard	**Application Received:**	09/16/2015

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: Preventive Medicine, Occupational Medicine

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 53 year old male, who sustained an industrial injury on June 25, 2000, incurring left knee injuries. He was diagnosed with left knee anterior cruciate ligament (ACL) tear. He underwent surgery to the left knee eleven times included an ACL reconstruction and patellar tendon reconstruction. He underwent a right knee arthroscopy on November 5, 2010. He was administered Kenalog to the right knee in February, May and August 2011. Other treatment included pain medications, rest, ice, bracing, and activity restrictions and modifications. Currently, the injured worker complained of persistent left knee pain rating his pain 8 out of 10 on a pain scale from 0 to 10. He noted tenderness, sharp and achy pain interfering with his activities of daily living. He reported limited range of motion with loss of strength of the left knee. X rays of the left knee revealed severe patellofemoral osteoarthritis with patellar osteoarthritis and bone spur formation. The treatment plan that was requested for authorization on September 16, 2015, included Magnetic Resonance Imaging Arthrogram of the left knee. On September 1, 2015, a request for a left knee Magnetic Resonance Imaging was non-certified by utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI Arthrogram of the left knee: Upheld

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 & Leg Chapter/MR Arthrography Section.

Decision rationale: Per MTUS guidelines, special studies are not needed to evaluate most knee complaints until after a period of conservative care and observation. The position of the American College of Radiology (ACR) in its most recent appropriateness criteria list the following clinical parameters as predicting absence of significant fracture and may be used to support the decision not to obtain a radiograph following knee trauma: 1) Patient is able to walk without a limp. 2) Patient had a twisting injury and there is no effusion. The clinical parameters for ordering knee radiographs following trauma in this population are: 1) Joint effusion within 24 hours of direct blow or fall. 2) Palpable tenderness over fibular head or patella. 3) Inability to flex knee to 90 degrees 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. Per the ODG, arthrography is recommended as a postoperative option to help diagnose a suspected residual or recurrent tear, for meniscal repair or for meniscal resection of more than 25%. In this study, for all patients who underwent meniscal repair, MR arthrography was required to diagnose a residual or recurrent tear. In patients with meniscal resection of more than 25% who did not have severe degenerative arthrosis, avascular necrosis, chondral injuries, native joint fluid that extends into a meniscus, or a tear in a new area, MR arthrography was useful in the diagnosis of residual or recurrent tear. Patients with less than 25% meniscal resection did not need MR arthrography. In this case, the injured worker is diagnosed with osteoarthritis and there is no evidence of a diagnosis that would indicate the need for an MRA over an MRI. MRI is preferred to MRA. The request for MRI arthrogram of the left knee is determined to not be medically necessary.