

<b>Case Number:</b>	CM15-0183422		
<b>Date Assigned:</b>	09/29/2015	<b>Date of Injury:</b>	12/09/2013
<b>Decision Date:</b>	11/09/2015	<b>UR Denial Date:</b>	08/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/17/2015

### 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

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 66 year old female who sustained an industrial injury on 12-09-2013. A review of the medical records indicated that the injured worker is undergoing treatment for left knee internal derangement. According to the treating physician's progress report on 08-10-2015, the injured worker continues to experience left knee pain with swelling at the end of the day and disruption of sleep. The injured worker rated her pain at 8 out of 10 on the pain scale. Examination of the left knee demonstrated medial and lateral joint tenderness with range of motion at 0-120 degrees with painful crepitus. There was no discussion of prior diagnostic tests in the review. Prior treatments have included hinged knee brace and medications. Current medication was listed as Norco. On 08-10-2015 the provider requested authorization for left knee magnetic resonance imaging (MRI) with arthrogram times 1. On 08-18-2015 the Utilization Review determined the request for a left knee magnetic resonance imaging (MRI) with arthrogram times 1 was not medically necessary.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI with arthrogram left knee, QTY: 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Knee Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee Chapter, Indications for imaging - MRI (magnetic resonance imaging).

**MAXIMUS guideline:** Decision based on MTUS Knee Complaints 2004, Section(s): Special Studies.

**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 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. Per the ODG, MR arthrogram 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 had a previous MRI in January, 2014 that revealed moderately severe patellar chondromalacia, intramedullary lesion in the distal diaphysis of the left femur. She is diagnosed with a probable bone infarct and internal derangement of the knee. Per available documentation she complains of worsening pain. On examination there is decreased ROM with crepitus. A repeat MRI is warranted in this case due to worsening pain and decreased ROM with crepitus, however, there is no rationale for an MRA. Additionally, MRI is preferred to MRA, therefore, the request for MRI with arthrogram left knee, QTY: 1 is not medically necessary.